State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22, 2008 **Physician** Phillip Rochlin 10:15 A M July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Silver Spring 13607 Colgate Way #323 Montgomery 8. Date of Birth (Month, Day, Yea Mar 24, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** New York Months Days Hours 1**X** M 2□ F 85 1923 Director 081-18-2184 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show 1 ☐Yes 2 No MD Montgomery Silver Spring Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 USA 13607 Colgate Way #323 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1∑|Yes 2 □ No |If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 ☐ Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) Federal Government <u> Technical Librarian</u> permit. Pages 1 and 2 should be filed be peatment of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dora Rubin Louis Rochlin ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3350 Oak West Drive Ellicott City, MD 21043 Jennifer Rochlin/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory 07/25/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service License MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 NON54 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ducito (or as a sonsequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performed certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ithin 24 hours after death.

o the Funeral Director: A
ompletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 7 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 VUV KUI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JUL 25** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 For State Registra AMEND#10dperFH, 7-29-08, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:53AM Mary Frances Ries TULV 7,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Prince George's Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yes March 28, 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 🕇 F Months Days Hours Min Year) 579-50-1746 70 ´1938 Illinois Director Usual Residence of Decedent 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: if Hean 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. In a Madical Exymination as Deriodified and Yes -2 Taplo Directo MarylandPrince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5015 Edgewood Road 20740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 □Yes 2 No þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Joseph Connor Mary Veronica Connors ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carl August Ries, Jr/Husband 5015 Edgewood Road, College Park, MD 20740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Heaven Cemetery Gate of Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sure of Funeral Service Licens 22. Name and Address of Facility Funeral Home Inc. d, W,. Silver Spring, MD 20901 Francis J. Coll 500 University Blvd, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Peritonitis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Rupture of Diverticular Abcess Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burla-transit Diabetes Mellitus resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Vasculitis IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ∐ Yes 2 🔀 🖠 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 □ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∏Yes 2 X No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) vithin 2 To the I and manner stated. 29b. Signature and title of cortil 29c. License number 29d. Date signed (Month, Day, Year) D58182 July 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cecil George, MD 7500 Hanover Parkway, #101A, Greenbelt, MD 20770 31. Date filed (Month, Day, Year) State 💓. Registrar's Signature 24 Registra

			State of Marylai  For State of Marylai Registrar		artment of H		ntal Hygien	
			Decedent's Name (First, Middle, Last)			-	. Date of Death	ZUU 3 Time of Death J
	Physicia		Carl A. Rudbeck, Jr.				7 23	2008 6:17 P M
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ō	Phys this ral dir	2	1 ☐ Yes 2 ☐ NO ☐ 1 ☐ Inpatient 2  27. Manner of Death	ER/Outpatie	SIIL SU DOA	4 LI Nursing Hom	e Residence  Bd. Describe how in	6 ☐Other (Specify)
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. 1	3A10+1		30. Name and address of person who completed cause of death (II	tem 23a) (Type	e, Print)	mCITYI	BLVD. PE	7.24.08 John, MDZ18/1

31. Date filed (Month, Day, Year) State

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32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are spible. State of Maryland / Department of Health and Mental Hygiene

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			For State Registrar		Cei	rtifica	te of L	Death		Reg. No	),	
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F.	Funeral Director		5. Social Security Number 6. Se 215-44-9211 Usual Residence of Decedent	x	last birthday) Yrs.	If Unde Months		If Under 24 Hi Hours Mi	8. Date of B (Month, D 12-2	rth ay, Year) 8 – 1 9	9. Birth Con Hag	nplace (State or Foreign untry) [erstown,
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	0 5 5 0	i ta	19a. Informant's Name/Relationship (T) Margaret E. Ree			-		onal Pi	(2004-10) A	-		Tip Code) ID 21740
Baltimore,	age ent o nt: If y or		20a. Method of Disposition  1	Removal from State	Place of Dispo cemetery, crei dar Li	matory`or awn	Park	20	Ly <sup>Date</sup> 31,	Hag	ocation - City or T gerstow	m,MD
Balt	permit. P Departm Importar eny injur		21. Signature of Funeral Service Licens  23a. Partl. Enter the disease, or comp	7.	22	Name a Dona P.O.	Id Address BOX	Edwin 1	hompso	n Fu rinc	uneral	Home, Inc
100	Physician /Medical		23a. Part1. Enter the disease, of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the dealine cause on each line.  a	Cel	ter the mo	de of dyin	g, such as cardi	ac oncespiratory	arrest,		Approximate Interval Between Onset and Death
68760,	certificate be executed to the first state of the purial-transit to the first state of th	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consect  Due to (or as a consect								
O. Box 68	D Si	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3[	⊒Ectopic   ⊒ Other (s	oregnancy specify)				23d. Date of deli Month	ivery Day Year
S, P.	as thi	by	Part II. Other significant conditions co	intributing to death but not res	sulting in the u	inderlying	cause give	en in Part I.		tobacco Yes 2	_	the cause of death?
Vital Record	The ate h page	Completed							24a. Wa aut pen 1 ☐ Yes		prior to death?	topsy findings available completion of cause of 2□ No
o	ig Phys ter this neral di	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 0  27. Manger of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injun	er: 4 🗆 Nursing	Home 5 Res 28d. Describe	idence	6 □Other (Speciny occurred	Sify)
Division	el or Attendir s after death. il Director: Af id in by the fur	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury - At h building, etc. (Speci	ome, farm, str by)	reet, facto	ry, office		28f. Location City or To			ıral Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Directonpletely filled in by	edicai	29a. Certifier (Check only one) 12 Certifying Phy	vsicien: To the best of my kni iner: On the basis of examina and marner stated.	owledge, deat ation and/or in	h occurre ivestigatio	d at the tim	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s , date an	and manner as d place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	e		) 1	Oc. License		36	29d. Da	ate signed (Month	, Day, Year)
ف	4-16+1		Karen Jill Cicc	ompleted cause of death (Itel	202 K	Print)	lel	2d N	Villams	por	t MD	,2008 21795
	Sta Registi		31. Date filed (Month, Day, Year)	32. Redistrar's Sign	ature	Speed	20			4		

Division or Vital Records, P.O. Box 687600

the Maryland

Saltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit been signed by the should be detached certificate has be rector, page 2 s After this within 24 hours after death.

To the Funeral Director: <sup>A</sup> completely filled in by the fu

esulting in death) Last	Due to (or as a conseq	uence of):			
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of continuous	al death 3 ☐ Ectopic pr			23d. Date of delivery Month Day Year
art II. Other significant conditions	contributing to death but not res	ulting in the underlying ca	ause given in Part i.	23e. Did tobacc	co use contribute to the cause of death?
				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
5. Was case referred to medical			26. Place of De	eath Check onl o e	
examiner? 1 ☐ Yes 2 ☐ ₩0	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ DC	A Other: 4 Nursing	Home 5 ☐ Residence	e 6 Other (Specify)
7. Manner eath  1	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M	8c. Injury at Work? 1 ∐ Yes 2 ☐ No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not l determined		ome, farm, street, factory	, office	28f. Location (Street City or Town, Si	t and Number or Rural Route Number, tate)
Pga. Certifier 1 Certifying F (Check only one) 2 Medical Example 1	rhysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and pla , in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
Oh Signature and title of certifier		290	. License number	29d.	Date signed (Month, Day, Year)

066049

08-04-2008

Registrar DHMH 17 Rev 1/2001

P

State

Medical

31. Date filed (Month, Day, Year)

AUG 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY **18** 2008 8:30AM M MARTHA ELIZABETH SCHUETTE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL GENESIS HEALTH CARE SEVERNA PARK CENTER SEVERNA PARK 8. Date of Birth (Month, Day, APR 7, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1 □ M 2 🗶 1922 OHIO 287-18-7027 86 Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c, City, Town or Location 10a. State show in than "natural", or items 23a or 28a-f show the Wedleyl Evanings must be rutified at 1 ☐ Yes 2 XNo Director SEVERNA PARK ANNE ARUNDEL MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number TISA 21146 24 TRUCK HOUSE ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Specify: WHITE ò 3 ¥Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) TEACHER 12 EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H MARY ARCHER 1 and 2 should b Health and Ment tem 27 is marked DEWEY BUSH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 50, GIBSON ISLAND, MD 21056 REBECCA FOLKEMER/DAUGHTER tem ; 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 7/23/2008 | EASTON, MD 4 Donation 5 Dother (Specify) SPRING HILL CEMETERY 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licensee Doseph M. 120cmell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEAR ! Physician ATHEROSCLEROTIC CALDIOVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit Exami Due to (or as a consequence of) death certificate be Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ed by the a detached for ☐Yes 2 NO 9 Unknown 9 Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed certificate Attending Physician: 25. Be 27 Certification:

P.O. Box 68760, Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific, completely filled in by the funeral director,

			<u></u>			topsy rformed?	prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referre	ed to medical			26. Place of De	eath (Check onl)	y one)	
examiner? 1 ☐ Yes 2 🕰	ю	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3 □ D	OA Other: 4 Nursing	Home 5 ☐ Re	sidence 6	Other (Specify)
27. Manner of Death 1 Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □ No	28d. Describ	e how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		nome, farm, street, factor	y, office	28f. Location City or T	(Street and own, State)	l Number or Rural Route Number,
29a. Certifier (Check only one)		nysician: To the best of my kn miner: On the basis of examin and manner stated.					and manner as stated. place, and due to the cause(s)
29h Signature and t	itle of certifier		29	c. License number		29d. Date	e signed (Month, Day, Year)

D31136 JULY 18,2008

KICBRIDE RU BALTIMONE, MD 21236

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature 31. Date filed (Month, Day, Year, JUL 21 2008

12S 10

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) .°2008 Month July **Physician** 21, Albert Spencer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Shady Grove Adventist Hospital 9. Birthplace (State or Foreign Country)
Ohio If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 14, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **1**X M 2 □ F 84 287-16-6073 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination of the resultived at 10a. State 10b. County 10c. City, Town or Location Director MD Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 USA 442 Russell Avenue Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No Specify: White Completed by Year or Dates: 1943–48 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Marie Dean Elmer Ellsworth Spencer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 442 Russell Ave. Gaithersburg, MD 20877 Lois Spencer/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 07/25/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral S Clarksville, MO1251 Beverly L. Heckrotte, P.A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final aspir all Physician pheumonl disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, has this After

Completed Be

Certification: To Medical

25. Was case referred to medical examiner?

1 Yes 2 No

27. Many er of Death

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

filled in by the funeral director, page 2 should be after death Director: within 24 hours a To the Funeral D Hospital completely

1011

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b Time of

29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8:50P ™

10d. Inside City Limits

1 ZYes 2 □ No

MD 21029

4 🖪 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

24a. Was an

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy perform 2 No

28d. Describe how injury occurred

Approximate Interval Between Orlset and Death

a ans

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 91 teven Olinsk

32.

31. Date filed (Month, Day, Year) JUL 25 2008

5 Pending investigation

6 ☐ Could not be

			1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2	008 25509
	Physicia	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death	Year 3. Time of Death
	/Medic	al	At City Town and position of Dooth	ounty of Death
			11722 Bishops Content Mitchellville Pri	nce George's
b	Funeral Director		5. Social Security Number 046-28-5562 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) 71 Yrs. 71 Yrs. 71 Yrs. 72 Months Days Hours Min. Mar 26, 1937	9. Birthplace (State or Foreign Country) Connecticut
	iryland show	_	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1
	the Ma 28a-f	recto	MD Prince George's Mitchellville  10e. Street and Number 10g. Citizer	n of What Country?
	th with 23a or 1st be	al Di	11722 Bishops Content 20721 USA	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	3 □ Widowed 4 □ Divorced   If Yes, Give Year or Dates: 1954–60   1 □ Yes 2 ≥ No Specify:   Specify:	Race - American Indian, Black, White, etc.  Specify: White
5-0036	"natura	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	of Business/Industry
2121	d within giene. r than the Me	dmo	Elementary/Secondary (0-12) College (1-4or 5+) SH Attorney/Judge Law	
pui	i 2 should be filed w h and Mental Hygiel I is marked other th raumatic event, th	8e	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	
Maryland	should ind Mer marke	၉	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or T	
	1 and 2 Health a tem 27 is		Juanita G. Shepherd/wife 11722 Bishops Content Mitchellvill	
Baltimore,	Pages 1 tment of h tant: If Ite		1 ☐ Burial 2 MC cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Chesapeake Crematory 07/25/08  Belts	ation - City or Town, State
Bal	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee Coing Home Cremation Service P  22. Name and Address of Facility  Going Home Cremation Service P  MO1251 Beverly L. Heckrotte, P.A. Clar	ksville, MD 21029
	Physician /Medical	(C ()	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart farture. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Approximate Interval Between Onset and Death
8	Examiner	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
o,	ficate be executed g physician and ss the burial-transit	Examiner	cause. Erner Unwenying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):	
68760,	icate be physici s the bu	edical	d	
Box .	attending for use a	Physician/Me		ld. Date of delivery Month Day Year
rds, P.O	w requires that the desbeen signed by the sishould be detached	þ	Part II. Other significant continuous continuous to death out not resulting in the underlying cause given in Part I.	e contribute to the cause of death?  No 3 Probably 4 Unknown
Division or Vital Records,		Completed	24a. Was an autopsy performed P 1 □ Yes 2 1 □ No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Vita	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	
n or	iing Phys I. After this funeral di	on: To	On Data of Figure 1	
Division	or Attenditer death Director: in by the	Certification:	2 Accident investigation  3 Suicide 4 Homicide   Accident investigation   M   1 Yes 2 No    28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street and I building, etc. (Specify)    28f. Location (Street and I building, etc. (Specify)	Number or Rural Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce		
	To the H within 24 To the Fl complete	Me		signed (Month, Day, Year)
			065272	124/2004
(1	of the		30. Name and ddress of recent to completed cause of death (Item 23a) (Type, Print)  NSW TIKERY 900 BISTARE LINE SUITE SU	& MO ZILIOI
	Sta Registi		1111 0 × 0000   E.   L   A   A	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) Year 7723/2008 **Physician** 10:50 PM STANLEY FRANCIES SCHMIDT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OUEEN ANNE'S MILLINGTON 3823 MCGINNIS RD. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 □ F 216-30-0001 74 8/1/1933 MD Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 XNo MILLINGTON Director MD OUEEN ANNE'S permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f any injury or other traumatic event, the Morteau Experiment 2000. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21651 USA 3823 MCGINNIS RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: N/A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWNER/OPERATER FOOD PROCESSING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MERLE FRANCIES H. STANLEY SCHMIDT ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3823 MCGINNIS RD. MILLINGTON, MD 21651 GAIL SCHMIDT/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 7/24/2008 STEVENSVILE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
370 W. CYPRESS ST. MILLINGTON, MD 21651 21. Signature of Funeral Service Licenses Kein 23a. Part 1. Enter the disease, or corpolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3= **Physician** pressed disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury EDICAL EXAM Examiner the death certificate be executed primanar that initiated events resulting in death) Last CERTIFICATION Due to (or as a consequence of) burial-t physician the burial P.O. Box 68760. Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical examiner?
1 A Yes 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28d. Describe how injury occurred Subject fell off stack of hay in bed of pickup truck. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: After Hospital or Attending 24 hours after death. 2 Accident 5 Pending investigation 1 ☐ Yes 2 🛣 No 3:00p n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fi 06/05/2008 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Sudlersville Cemetery Road, Sudlersville,MD 3 Suicide 4 ☐ Homicide Barn Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the the within To the 29d. Date signed (Month, Day, Year) of certifier 29c. License number 29b. Signature and title 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hurch Hill Rd. Chestertown, MD 21620 De 1600 (S1) Signature 6602 trederick 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Norman Albert Stead 20, 2008 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Numbe 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 113-22-5480 77 New York Director June 27,1931 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shov sdical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Anne Arundel Annapolis Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n 21409 USA 1152 Locust Tree Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 N Yes 2 No Korean 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2√2 No Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: War 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervising Technician Military Academy 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amanda Houck Albert Stead P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1152 Locust Tree Drive Annapolis, MD 21409 Ingrid Stead/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) July 22, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, Maryland 2008 4 □ Donation 5 □ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 21. Signature of Fineral Service Licenses Mez Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Stem Organ resulting in death) /Medical Due to (or as a cons ruence of): Examiner Q 276 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) the detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed or Vital Records, pe 2 No 3 Probably 4 Unknown 1 □ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 2 □ No 1□ Yes 2 100 1 TYes Physician: ector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2010 1 Hnpatient 2 ER/Outpatient P 3□ DOA this funeral 27. Manne Leath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division or Attending (Month, Day Year) 1 I atural 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier (Check only one) 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

State

Signature and little of certifier

MOWERD

31. Date filed (Month, Day, Year)

JUL 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32 Registrar's Signature

29c. License number

00005829

29d. Date signed (Month, Day, Year)

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i i	Physici	an	Decedent's Name (First, Middle,	,						2	. Date of De	athuly Da	y48,	2008	3. Fimb of	Death Z
	/Medi		Kathryn M. Smit								July 1		908		9:55	Рм
	Examir	ner	4a. Facility Name (If not institution,		,			_	Location of	Death		4c.	. County o	of Death	_	
			Crofton Convale 5. Social Security Number	escent Ce		rs. last birthd	Crof		If Under 2	4 Hrs To	Data of Ric		ne A		ace (State o	
	Funeral Director		193-14-0947	1 □ M 2 🂢 F	93		Months		Hours	Min	Month, Date of Bir (Month, Da Ine 15	y, Year) , 19	15	Coun	ace (State o try) sylvan	
	yland now		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or	Location				-			10	d. Inside Ci	ty Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Mydical Examinat must be notified at once.	Director	PA Erie		Eri	e									X□Yes	2□No
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Baltimore, Maryland 21215-0036	ral", o	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ve		1 □ Yes	2 <b>X</b> No	Specify:				Specify:	Whit	ie.	
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lar	2 sho and l		19a. Informant's Name/Relationshi	p (Type. Print)		19b. Ma	ailing Address	(Street a	and Number	or Rural F	Route Numb	er, City o	or Town, S	State, Zip	Code)	
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Вох	h cert endin use	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out									23d. Date	of delive	ry	
	ie deet the att hed for	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 No		oirth 2□Fe nant at time o own		3 ☐ Ectopic p 5 ☐ Other <i>(sp</i>						Mont		•	'ear
P.0	that the ded by the detached		9 ☐ Unknown N			esulting in the	underlying o	auso dive	on in Part I		23e Did t	obacca u	uso contrib	auto to th	e cause of de	ooth?
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	To the Hospital or Attending Physician: The law requires that the deeth certificate be within E4 hours after death. Within E2 hours after death. To the Tay been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but	edical (	29a. Certifier (Check only one)  Certifying  Certifying	Physician: To the kaminer: On the ba	asis of exami	nowledge, de nation and/or	eath occurred investigation	at the tim	ne, date and pinion, death	place, and occurred	d due to the at the time,	cause(s)	) and man d place, ar	ner as st	ated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	M.		· 1	29c	. License	number			29d. Dat	te signed	(Month, E	ay, Year)	
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Physician /Medical Examiner

Physici /Medi Exami

**Funeral Director** 

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	Registrar  1. Decedent's Name (First, Middle, Las	st)			icate or E	Catri	2. Date of Dea	Reg. No. ath	2008	3. Time of Death
ı	Elizabeth Cleo	смтти					Month	Day	3 200	8 2312 PM
ľ	4a. Facility Name (If not institution, give		r)	4b.	. City, Town, or	ocation of Death		4c.	County of Dea	ath
	Washington Cou	nty Hospi	tal		Hag	erstown			Washing	ton
Ī	Social Security Number     6. S	ex 7. A □M 2X F	kge (In yrs. last bir	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year)	C	rthplace (State or Foreign ountry)
-	214-34-9441 Usual Residence of Decedent	- W - W -	72	Yrs.			\$ept. 4	193	5 Vir	ginia
H	10a. State 10b. County		10c. City, Tow	n or Location	on					10d. Inside City Limits
	Maryland Washin	oton	н	lagers	town					1 <b>X</b> Yes 2 □ No
ŀ	10e. Street and Number	6011			Of. Zip Code			10g. Cit	izen of What Co	ountry?
	222 N. Jonathan	Street			217	40			USA	
ľ	11. Marital Status	12. Was Deceden		13. Was	Decedent of His	panic Origin? (S , Mexican, Puert	pecify Yes or No	-	14. Race - Ame Black, Whit	
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	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Coo				Re	stauran	ıt.
	17. Father's Name (First, Middle, Last)		1	000		18. Mother's Nan	ne (First, Middle,			
	Unknown					Martha	Broadus	3		
	19a. Informant's Name/Relationship (	Type. Print)	196	b. Mailing Ad	ddress (Street a	nd Number or Ru	ıral Route Numbe	er, City o	or Town, State,	Zip Code)
	Jerome Broadus -	Grandson	1	006 S	ecurity	Road	Hagersto	own,	Md. 21	.742
	20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐	Demoval from Stat	20b. Place o	of Disposition ery, cremator	n (Name of ry or other place	)	Date	20c. Lo	ocation - City or	r Town, State
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	21. Signature of Funeral Service Licer	see		1 1	ame and Addres		innich I			
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WH-3 State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Birbhrh A. Hucklir MD 24 Nirth Willing

31. Date filed (Month, Day, Year)

32. Registrar's Signature MD 24 North Walnut Street Suite 102, 32. Registrar's Signature

Hugustown, MD 21740

			For State	State of Maryland		artment of Hertificate of L			21118	25514
- 47	( ) ( )	¥	Registrar  1. Decedent's Name (First, Middle, Las	")	Oei	uncate of L	- Calli	Reg. N	10	3. Time of Death
	Physicia		Carrie F.	Scibilia				July 28,	2008 Year	6:02 P M
V.	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		c. County of Death	
	Lxaiiiii	بر شر	10611 Oak Tree	Circle		Willia	msport		Washi	ngton
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea NOV • 2, 19	9. Birth	place (State or Foreign intry) insylvania
	Director		152-09-0876	JM 21X F 97	Yrs.			Nov.2, 19	10 Per	nsylvania
	and w	-	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryi	ō	Maryland Wash	ington		William	sport		1	XXYes 2□No
	1 the	Directo	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Cou	intry?
	13a o	0	10611 Oak Tree	Circle		21	795		USA	1
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
õ	itled within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or itlems 23a or 28a-f ehow int, the Medicel Examiner must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 XXVo If Yes, Give		1 ☐ Yes 2XXNo	Specify:			/hite
ğ	hours ture!;	d by	3√Widowed 4 □Divorced  15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occupa	ition	16h	Kind of Business/l	
,	in 72 "nal	Completed	(Specify only highest gra-	de completed)	(Give	kind of work done d DO NOT use retired;	luring most of world)	ting	Turio or basinosari	nadatiy
7.17	I with	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Mac	hine Oper	ator		Manufacti	uring
פ	0 =	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Maid	en Surname)	
<u>la</u>		ToE	Jacob Mil	ка				herine	Shliv	
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (7					ral Route Number, City		1
	s 1 and 2 should of Health and Mer Itam 27 is marke other traumatic		John Scibilia - So  20a, Method of Disposition						Ort, Mary	/land 21795
ŏ			XXBurial 2 Cremation 3	Hemoyaj irom State		osition (Name of matory or other place			•	
			4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen			Cemetery			brunswic	ck,New Jersey
Ba	permit. Departr Importa		1 1	<u> </u>					liamspor	t, MD 21795
	3		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused the death						Approximate Interval Between
y.	Physician		Immediate Cause (Final disease or condition	£-1/0 (7	NOF	Demen	TIA			Orset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):	Januar	((')			101103
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	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
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ŏ	death certific e attending p ed for use as I	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of deli	·
en en	D 00 0	Physician/Me	in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at time of de		Other (specify)			Month	Day Year
o O	res that the de signed by the a be detached f	Phy			Mine in the	4-8/-	- in Dead	23a Did tahasa	o uso contributo to	the cause of death?
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ecords,	w require been si should 1	etec							70	
Rec	: The law cate has i	Completed						24a. Was an autopsy performed	death?	topsy findings available completion of cause of
Vital		ေင့	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2 ☐ th (Check only one)	No 1 ☐ Yes	2 No
	yeician: is certific director,	To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Othe		./	6 ☐Other (Spec	cifv)
Division of	Attending Physician: r death, sctor: After this certific by the funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how in		
Ö	Attendir death. ctor: Af y the fur	atlc	1 Natural 5 Pending 2 Accident Investigation				Yes 2 □No			
Ĭ		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (Street City or Town, St		ral Route Number,
	Hospital		29a, Certifier 1N Certifying Ph	ysician: To the best of my kno	wladaa daat	th Conversed at the time	a data and place	and due to the cause	(a) and manner as	ctated
	표 22 표 교	edicai	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	tion and/or in	ivestigation, in my of	pinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and trille of certifier	1		29c. License	e number	29d	Date signed (Monti	h, Day, Year)
			MZIII	Family 14	451611	n Dr	700	·	UC4 29,	500f
•	,		30. Name and address of person who	completed cause of death (Item	23а) (Туре	Print)	IL.		1111-	
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	Sta Registi		31. Date filed (Month, Day, Year)  JUL 29 2	32. Redistrar's Signa	IUITO	Sorales	`	,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-fence are 9882-08/15/08dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William Zeller SHUMAN 4:30 p. July 24, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 109 S. High Street Funkstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 X M 2 □ F Director 214-09-5811 Aug. 8 1909 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shor Director 1 Yes 2 □ No Maryland Washington Funkstown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 109 S. High Street 21734 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW 1] Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 TNo Specify. <u></u> Specify: White 3 ☐ Widowed 4 ☐ Divorced WW 11 Completed d other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other thar ther traumatic event, the M 0 Labor Shoe Mfg. 17. Father's Name (First, Middfe, Last) Be John Franklin Shuman ၉ Myrtle Bane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. Sandra Phillips - Granddaughter Funkstown, Maryland 21734 P.O. Box 630 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 7/25/08 Hagerstown, Marvland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEBILIT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner APPROVED BY MEDICAL EXAMINES Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ cate has been si 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1 ☐ Yes 2 **1**No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1☐XYes 2☐No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 09/14/2007 7:08 <del>1'⊞Net</del>ural 2**XX**Accident 5 Pending To the Hospital or Attendit within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu death. 1 □Yes 2 No Subject slipped and fell. investigation **p** <sup>M</sup> 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 23 Green Street, Funkstown, MD determined 4 Homicide Roadway 1 🔽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

00 H3+1

P.O. Box 68760,

Division of Vital Records,

ILLIAM 31. Date filed (Month, Day, Year) State JUL 28 Registrar

11110 MEDICA m.0.

toypto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

21742

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:50 P M Stevens 30 2008 Virginia July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Jan. 5; If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Country)
Maryland Days Hours 1 □ M 2 🔀 F 60 Director 218-50-3349 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evan, front inst be notified at 1 □ Yes 2 No Director MD Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21740 15818 Fairview Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 M Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental F thand 2 should by Health and Ment Oscar Derr Emma V. Cauffman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph R. Stevens/Husband 15818 Fairview Rd., Hagerstown, MD Pages 1 ament of H 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or c 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park | 8/4/2008 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 21742 1601 Pennsylvania Ave., Hagerstown, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SPIRATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of and that initiated events resulting in death) Last physician ar Due to (or as a consequence of) Box 68760, death certificate be Physician/Medical as IF FEMALE: use yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Por Month Day 4 Pregnant at time of death signed by the a 5 Other (specify) 0 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 No CERENROVASCULAR 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an EPHALOMALACIA certificate has autopsy performed page 1 ☐Yes 2 ☐ No 1 □Yes 2 No rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural (Month, Day, Year) 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 1 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG -

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 JULY 18, **Physician** 06:10P M NORA RUTH TAYLOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN KENT CHESTER RIVER MANOR 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/29/1927 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 K MD Director 213-24-3309 80 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show d other than "natural", or items 23a or 28a-f sho event, the Wediest Evaning roust be notified at Director 1 ☐ Yes 2 XNo MD KENT ROCK HALL 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? with 21413 E. SHARP ST. 21661 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 2 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or Itel 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify <u>Ş</u> Specify: 3 ☐ Widowed 4 💢 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 SEAMSTRESS MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evone. UNKNOWN BESSIE T. PRICE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. HILDA CORNELIUS/SISTER 21413 E. SHARP ST. ROCK HALL, MD 21661 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) WESLEY CHAPEL 7/23/2008 ROCK HALL, MD 21. Signature of Fyneral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
30 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULLIANARY ARREst **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Methototic Sevenius all Callinonia of Willia Due to (or as a consequence ): To LOFT Pelvis And Bone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death for 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2 □No P.O. the detached 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗆 No 1 ☐ Yes 2 ENO 1 ☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1No 1□ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this hin 24 hours after death.

the Funeral Director: After thi
mpletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

31 Date filed (Month, Day, Registrar

30. Name and

address of person who completed cause of death (Jem 23a) (Type, Print)

32. Reg

Th, W.S.

223/tigh Street, CHENTESTOWN, Jud 21620

			For State Registrar	State of Mar		artmer			nd Me		giene Reg. No.	008	25518
N.	Physici /Medi		1. Decedent's Name (First, Middle, La	THOR	NE					Date of Dea	nth Day	Year ZOOS	3. Time of Death 2.57 PM
	Examir		4a. Facility Name (If not institution, giv Lorriane Nursin				Town, or umbia	Location of		/	4c. Cou	unty of Death oward	
	Funeral Director		5. Social Security Number 6. S 579 22 6617  Usual Residence of Decedent	ex 7. Age ( □M 2万 F 90	n yrs. last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	Date of Birt (Month, Day ay 17,	/, Year)	Cou	place (State or Foreign ntry) Va, PA
	Maryland -f ehow	tor	10a. State 10b. County  Maryland Howard	1	Oc. City, Town or Lo	ocation	ia						10d. Inside City Limits 1 ☐ Yes ※※ No
	th with the 23a or 28e	al Director	10e. Street and Number 6438 Amherst A	ve		10f. Zi	p Code 21	046				of What Could	•
9800	s 1 end 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23s or 28e-f ehow other treumstic event, the Medical Examinar must be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3XXVidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2√7 No If Yes, Give A Year or Dates:		Was Dece If Yes, spe 1  Yes	ecify Cuba	spanic Origi n, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)	14.	Race - Americ Black, White, ecity: Whi	can Indian, etc.
121215-0036	led within 72 h lygiene. her than "natu it, the Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1.2	College (1-4or 5+)	16a. Dece (Give life. RN		ork done d	furing most (				Medica	•
Maryland	nould be fi d Mental H narked oti natic ever	To Be	17. Father's Name (First, Middle, Last, Dow L. Miller					A	1medi	First, Middle, _a Heri	ritt		
e, Ma	1 end 2 sl Health and 1 sem 27 ls reur		19a. Informant's Name/Relationship ( Robert Thorne  20a. Method of Disposition	**	20b. Place of Dispo	64	38 Aı			, Colu	mbia,	$\frac{MD}{D}$ 210	046
Baltimore,	t. Page rtment o rtent: If		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer	y)	Cedar H	i11 C	emete	erv Ju	11y 28	3, 200	8 Suit	·land	Maryland
Ba	permi Depe Impo eny ir		23a. Part I. Enter the disease, or com	MO,	1011	Alexa	ndria	ı Ferr	y Roa	ad, C1	inton,	∍, Inc , MD 20	6633 01d 0735 Approximate
	Physician /Medical	Į.	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  SEP  Due to (or as a c	sis								Interval Between Onset and Death
*** ***	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		TRIDI	U 1	1 7	)   FF	F) (1	LE	COL	,715	days
8760,	cate be executed physicien and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. URIN Due to (or as a c		12A	A C7	11	JFE	(710)	V	C	nonelt
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 if 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	□Ectopic p □ Other (s					23d.	Date of deliver	ery Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ontributing to death buf i	not resulting in the u	inderlying	cause give	en in Part I.			es 2 N		he cause of death?
Vital Records,		Completed										prior to co death?	opsy findings available impletion of cause of
	Physician: Th this certificete ral director, paç	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ №	Hospital: 1 ☐ Inpatient	2 ER/Outpatier		OA Othe	ar-		Check only o			
ion of	inding Physiath. ir: After this ie funeral di		27. Manner of Death    Matural 5   Pending investigation	28a. Date of Injury (Month, Day Y	28b. Time o		28c. Injury Work	Allmurs	280	5 Hesid		Other (Special Courred	(y)
Division	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, sti (Specify)	reet, factor	ry, office		281	Location (S City or Tow	itreet and Norm, State)	umber or Rura	al Route Number,
	To the Hospi within 24 hou To the Funer completely fill	Medical	one)	ysician: To the best of r niner: On the basis of ex and manner state	d. damination and/or in	vestigation	n, in my op	iinion, death	occurred	at the time,	date and pla	ce, and due to	o the cause(s)
	To To	2	29b. Signature and title of certifier	LIMD		29	c. License	number	10	,	29d. Date si	gned (Month,	Day, Year)
(	1355		30. Name and address of person who	completed cause of deal	th (Item 23a) (Type,	Print)	0 90	2nh	200	Rd S	ruel	211C	) _
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 5	32. Refistrar's	Signature	back	٠,			001.	umb	oce M	0 राज्य

State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death JULY 22, Day 2008 ear **Physician** INEZ REBECCA TURNER 5:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House MONTGOMERY Rockville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT • 31, 1922 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Hours Min Days Maryland 579-28-0133 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f show event, the Wedical Example rough to modified at Director Yes 2 □ No MD Montgomery Gaithersburg the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Chestnut Street, #212 U.S.A. 20877 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ∏Yes 3€ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify þ Specify: Black 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National 4H Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than 10th Head Housekeeper Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental important: If Item 27 Is marked of any Injury or other traumatic eve once. ပ Joseph Johnson Frances Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosslyn G. Edwards (Daughter) 3908 Jack Pine Ct, Greensboro, NC 27406 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Mem. Park 7/26/08 Olney, MD 21. Signatury of Funeral Service License 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pancreatic Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit be executed Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 25 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 1 ☐Yes 2 ☐ No 2 XNo director 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:  $4 \square$  Nursing Home  $5 \square$  Residence Schother (Specify) Hospice Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation Natural death. 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Description\*\*

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check one) the ithin To the 29b. Signatu re and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) D064615 7/22/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Génevieve Wroblewski, M.D. 6001 Muncaster Mill Rd, Derwood, MD 20855 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Margot Kathy Temp 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Dorches Campridge Genera If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan . 29 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs , 1935 Hours 1 □ M 2 🗓 F Days 579-46-8746 73 Germany Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Dorchester Cambridge MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1744 Brannocks Neck Road 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ X lo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) landscaping 8 secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) August Erna Bredenbeck Huberti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1744 Brannocks Neck Road Cambridge, MD 21613 Siegfried Kurt Temp husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Salisbury Crematory 107/21/08 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ThomasFuneral Home, P.A. 700 Locust Street, Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) monas a consequence of): 170099 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably → Inknown

**Physician** /Medical Examiner law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

other traumatic event,

ö mportant: injury

h and Mental F is marked of

of Health a

Director

Funeral

Completed by

Be

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with the Maryland

filed within 72 hours after

Pages 1 and 2 should be

Baltimore,

P.O. Box 68760

Division or Vital Records,

Physician:

Hospital or Attending

burial-trar physician the as attending p ed by the detached signed b page 2 certificate this After th funeral To the Hospins.
within 24 hours after death.
To the Funeral Director: Aft

Exami Physician/Medical Completed by Be ပို Certification:

		autopsy performed?  1
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1  Yes	Hospital: DOA Other: 4 ☐ Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Manner of Death  12 Natural  2 Accident  5 Pending investigation	(Month, Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
	rsician: To the best of my knowledge, death occurred at the time, date and place, a iner: On the basis of examination and/or investigation, in my opinion, death occurre	

State Registrar

Medical

29d. Date signed (Month, Day, Year)

30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1- State Amend 16ab DOR, 7/24/08, SLB 25521 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Edward Thomas 1020 AM July 2008 Samuel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital at Easton Memorial EASTON Talbot 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 214-42-8066 1 M 2 □ F Months Days Hours Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits Department of Health and Mental Hygiene. Inputs arise useatif with the Wildylat Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Talbot **Funeral Director** Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Moton 21601 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use relired)

Landscape Contractor Landscaping Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be homas, ဥ SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Niece) Bernice Avenue-Baltimore, MD. 21229

Date 20c. Location City or Town, State Darlene 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Bunal 2 ☑ Cremation 3 ☐ Removal from State Charles thomas (emetery 7/26/08 St. Michaels, MD.

22. Name and Address of Facility
HENRY FUNERAL HOME, P.A.

510 washington St. Cambridge, MD. 21613

Approximate 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No this certificate 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Inpatient 2 R/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann ≠ of Death 1 ≠ atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 No 2 Accident filled in by the within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 A critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 044413

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Samue

Dr. Walter D. Gianelle, 219 S. Washington St. Easton, Md 21601

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For	State of Maryland			ntal Hygiene		05500
			State Registrar  1. Decedent's Name (First, Middle, La	set)	Certificate of		Reg. No.	2008	25522
	Physicia /Medic		James	Thorn		2	Month Day		AND 400
	Examin		4a. Facility Name (If not institution, gire	ve street and number)		or Location of Death	46.		ii
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last	t birthday) If Under 1 Year	over 24 Hrs. 8	Date of Birth (Month, Day, Year)	nne H	place (State or Foreign intry).
	Director		771 70-100	12M 2□F 7	Yrs. Months Days	Hours Min.	(Month, Day, Year)	134 Cou	DE DE
	yland 10w		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	Town or Location				10d. Inside City Limits
	8a-f sh	ctor	MD Anne A	rundal Ho	anover				1 Yes 2 □ No
	and the	Funeral Director	10e. Street and Number	Ionia Drive	10f. Zip Code	2010	10g. Cit	izen of What Cou	intry?
	r death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Amed Forces?	13. Was Decedent of H	tispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ameri Black, White,	
336	urs afte	by	1 Never Married 2 Married  3 Widowed 4 Divorced	147 Yes 2 □ No If Yes, Give Year or Dates:	1□ Yes 20 No	Specify:		Specify: B	ack
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, Ite Madical Extra directional by the lifted at	Completed	15. Decedent's E (Specify only highest gr	ducation 1 ade completed)	16a. Decedent's Usual Occup (Give kind of work done	during most of working	16b. K	ind of Business/Ir	ndustry
2121	filed within Hygiene. Ither than '	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Silfe. DO NOT use retire	Major	- 10.	SAr	my
and		Be	17. Father's Name (First, Middle, Las			18. Mother's Name (	First, Middle, Maiden		J
Maryla		<sup>2</sup>	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street	and Number or Bural I	-	eld	n Code)
	nd 2 lith a 27 ls		Laren Thos	a daughter	1408 Maced				m \$1076
Jore	Pages 1 annent of Heannt: If Item		20a. Method of Disposition  Burial 2 Cremation 3 [	Removal from State	e of Disposition (Name of etery, crematory or other pla	ce) Dat	20c. Lo	ocation - City or T	own, State
Baltimore,	그린밥을 .		21. Signature of Pureral Service Lic	BR Hall	gron Nationa 22. Name and Addre	ess of Facility	19008 HC	lington	Con Home
ň	permi Depa Impo any io		1 assort	Alahmar	- 1426 E.	Dover		aston	MD 21601
	100		23a. Part1. Enter the fine set, of con shock, or heart failure. List only Immediate Cause (Final	nplication, that a used the death. If		ng, such as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
ä	Physician /Medical		disease or condition resulting in death)	a Due to (or as a equen	CANCEV 100 of):				MONTIS
	Examiner	-	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequen	ne of).				
	oted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.	ice oi):				
90,	sate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as a consequen	ace of):				
68760	certificate be executed nding physician and use as the burial-transit	edical		d					
Box	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		y		23d. Date of deliv	
Ó	0 0	yslcl	1 Yes 2 No	4□Pregnant at time of deati 9□Unknown				Month	Day Year
S,	law requires that the de as been signed by the a 2 should be detached t	by Pr	Part II. Other significant conditions	contributing to death but not resultir	ng in the underlying cause giv	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ecords,	w require been sly should t		1					□No 3□Pro	bably 4 DUnknown
r	o - 6	Completed					24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Vital	nysiclan: Th nis certificate director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death (	Check only one)	1 ☐ Yes	2 □ No
ō	Phys this al di	1: To	1 ☐ Yes 2 No 27. Magner of Death		VOutpatient 3□ DOA Oth	ner: 4 ☐ Nursing Home	5 X Residence		ify)
lo 10	ttending I death. ctor: After y the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) on	Injury Wo	rk? Yes 2 □ No	o. Ecoure o Now Inju	y 000an 00	
Division	or Attendater deat Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		e, farm, street, factory, office	28	f. Location (Street ar City or Town, State		ral Route Number,
_	e Hospital or 24 hours afte e Funeral Dir etely filled in		29a. Certifier 1☐ Certifying P	hysician: To the best of my knowle	edge, death occurred at the ti	me, date and place, an	d due to the cause(s	) and manner as	stated.
	To the Hospital or A within 24 hours after To the Funeral Dira completely filled in b	Medical	(Check only one)  2 Medicel Exa 29b. Signature and title pertifier	miner: On the basis of examination and manner stated.	and/or investigation, in my o			te signed (Month,	
Т	25 25		) dino		7	54853	290. Da	7/16	12008
1			30. Name and address of person who	completed cause of death (Item 23	3a) (Type, Print)	. 0.1	Oda I	The said	77117
	10+3 Sta	tę	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Armapola	s Rd,	Odento	my my	11 × 11 ×
	Registr		JUL 1 7 2	32, Registrar's Signature	And				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day **Physician** James Charles Varipapa 2008 July 20, 3:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 344 Hamlet Circle Anne Arundel Edgewater If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours New York 88 8/27/1919 Director 099-09-2937 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event than "activation". 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland| Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 344 Hamlet Circle 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1940–45 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Bail Bondsman Bail Bonding 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Casimiro Filomena Eleina Varipapa Varipapa ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis S. Varipapa/ Wife 344 Hamlet Circle, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 7/26/08 21. Signaturi 1 Funeral Squirce Icenses 4 Donation 5 Dother (Specify) Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of - ibrill a tros Physician: The law requires that the death certificate be executed burial-tran attending physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No P Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ģ cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by as 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1∐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

completely within 24

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

State

Robert M. Greenfield, M.D. 31. Date filed (Month, Day, Year)

JUL 2 2 2008

29b. Signature and title of certifier

(Check only

139 Old Solomons Island Rd., Annapolis, MD 21401 32. Pogistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

26375

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State o	f Marylai		artment of rtificate of			lental Hy	giene	200	8 25	524
Physician			1, Decedent's Name (First, Middle, Last)					2. Date of De Month			3. Time			
-	/Medi	cal	Leopoldo B. V							July	19	2008	8:50	o P <sup>M</sup>
3	**Asaminer** (4a. Facility Name (If not institution, give street and number)** 837 Chestnut Tree Drive			4b. City, Town, An	or Location napo.				County of De					
	Funeral		5. Social Security Number 586–60–1901	5. Sex 1 <b>XXX</b> M 2 □ F	7. Age (In yrs 85	. last birthday) Yrs.	If Under 1 Year Months Days		der 24 Hrs. S Min.	8. Date of Bir (Month, Da	ı <i>y, Year)</i>		Birthplace (State Country)	
	Director		Usual Residence of Decedent		03	115.				4/28/	1923	P	<u>hilippir</u>	nes
	larylan show	'n	10a. State 10b. County Maryland Anne A	rundel	10c. C	ity, Town or Lo		apol:	is				10d. Inside (	City Limits
	r 28a-1	irect	10e. Street and Number				10f. Zip Code				10g. Citi;	zen of What (		
	ath with	ralD	837 Chestnut Tr	ee Drive				2140	09			U.S.		
920	be filed within 72 hours after death with the Maryland that Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Evanime must be notified at	by Funeral Director	11. Marital Status  1 Never Married XXMarried 3 Widowed 4 Divorced	Armed Fo	2 No		Was Decedent of fYes, specify Cult I ☐ Yes 2000 No			ecify Yes or No Rican, etc.)		<ol> <li>Race - Ar Black, Wh</li> <li>Specify:</li> </ol>	merican Indian, nite, etc. Asian	
15-0	"natur	leted	15. Decedent's (Specify only highest	Education grade completed)		1 (Give	dent's Usual Occu	durina m	ost of worki	ng 1	16b. Kir	nd of Busines	ss/Industry	
21215-0036	y within giene.	Completed by	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. i	OO NOT use retire Chef	ed)			U.S.	Gove	nment	
O	should be filed v nd Mental Hygie marked other i matic event, to	a)	17. Father's Name (First, Middle, La Gaudencio Vist			1				(First, Middle,	Maiden S	Surname)		
Mari	d 2 sho th and 7 is ma trauma		19a. Informant's Name/Relationship Bienvenida Vis			19b. Mailir	g Address (Stree nestnut !	t and Nur	mber or Rura	al Route Numbe	er, City or	Town, State	, Zip Code)	11.400
re,	s 1 and of Healt item 2 other		20a. Method of Disposition		20b.		sition (Name of natory or other pla			ate AIIIaL			or Town, State	21409
imo	Page ment c ant: If lury or		1 ☐ Burial 2XXCremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)		ltimore	e Cremato	ory		/2008			e, Maryl	
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		21. Signature Funery Service Lic	E T	Ill	14	Name and Addr 17 Duke o	ess of Fac of Gl	ouces	hn M. T ter St.	aylo , An	r Fune napoli	eral Hom s, MD 2	ie 1401
E			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Bet								ite etween			
'n	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Hepatitis B reactivation with hepatic failure  Due to (or as a consequence of):						0,100, 0,10					
	Examiner	_	Sequentially list conditions,	b. ————										
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):										
o,	icate be executed physician and s the burlal-transit	Exa	that initiated events resulting in death) Last	c Due to (	or as a consec	uence of):						<del></del>		
68760,	ficate be executed physician and s the burfal-transit	dical	d											
P.O. Box (	ath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   9   Unknown   1   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   1   Unknown   1   Unknown						2	3d. Date of d Month		Year		
	es that the de igned by the be detached i	by Ph	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the ur	derlying cause giv	en in Par	t I.	23e. Did to	bacco us	e contribute	to the cause of	death?
ord	w require s been sig should b	ted	Diffuse large		Tympho	ma				1 🗆 Y	es 2	]No 3□1	Probably 4 🔼	Unknown
Division of Vital Records,	ifcian: The law certificate has b ector, page 2 sh	Completed	Acute renal i	failure						24a. Was a autop perfor 1 □ Yes	sy med?	prior to death?	autopsy findings o completion of e	available cause of
<b>*</b>		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient 2	ED/Outpation	Ott			(Check only or				
n o	ding Phys h. After this funeral dii	i.io	27. Manner of Death  ★★Natural 5 □ Pending	28a. Date		28b. Time of Injury	28c. Inju			ne 5 <b>24</b> esid 28d. Describe h			pecify)	
<u>si</u>	Attendi death. ctor: A y the fu	licati	2 Accident investigati 3 Suicide 6 Could not	he t	of Injury - At he		M 1	Yes 2						
<u>&gt;</u>	tal or A s after al Direction by	Certification:	4 ☐ Homicide determine	d 20e. Place buildir	ng, etc. (Specil	y)	et, factory, office		2	<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>			nber,	
	S 3 5 -	Medical (	29a. Certifier  (Check only one)  1 Certifying I  2 Medical Ex	Physician: To the aminer: On the ba	asis of examina	owledge, death ation and/or inv	occurred at the ti	me, date opinion, d	and place, a eath occurre	and due to the e	cause(s)	and manner place, and du	as stated. ue to the cause(s	s)
	Not the company of th	Σ	29b. Signature and title of certifier	3-	m	7	29c. Licens	e numbe 0124		2		signed (Mor	nth, Day, Year)	
L	HOLL		30. Name and address of person wh Christina Maleki	o completed cause	e of death (Iten	n 23a) (Type, F	Print)	O D.	nbl	1				
P	Stat	е	31. Date filed (Month, Day, Year)	32 🖼	dietrar's Signa	turo	in Avenu	= 136	cnesc	a, Mary	/Lanc	2088	39	
	Registra	ır	JUL 2 3	2008	sever.	K A	rede							

**Physician** 

/Medical

HTLDA

10a. State

Md.

12

Director

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Examiner

Physician/Medical

2

Completed

Be

Certification: To

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended#31perFCHD, KS 7/23/08 ertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month PAGE WHITE JULY 5:35 P M 2008 21 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Norbeck Road Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□M 2XF 577-03-9380 91 18 1916 Nov. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4203 Norbeck Road 20853 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 1 No Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator Hardware 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Francis Page Rachel (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence P. White / Son 4203 Norbeck Road, Rockville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 7/25/08 4 □ Donation 5 □ Other (Specify) Norbeck Memorial Park Olney, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Muriel H. Barber Funeral Home H. Bara marriel Box 5038, Laytonsville, Md. 20882 P. O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Renal Failure disease or condition One Year resulting in death) Due to (or as a consequence of) Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Stroke, History of Pneumonia 1 Yes 2 Yoo 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of Feeding Tube 24a. Was an autopsy performe death? 2 No 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☑ No Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier D 23124 July 22, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis M. Hannon, M.D.

2901 Olney-Sandy Spring Road, Olney, Md. 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 3 2008

State Registrar

State of Maryland / Department of Health and	Mental Hygier
Certificate of Death	Reg. N

			1 - State Registrar	Ce	artment of He rtificate of D		-	giene <sub>Reg. No.</sub> 2 (	108	25526
8	Physicia	2.0	Decedent's Name (First, Middle, Last)				2. Date of De Month		Year	3. Time of Death
/iviedical			Alice Kuffner			July	18	2008	6:45 aM	
	Examiner  4a. Facility Name (If not institution, give street and number)			7)	4b. City, Town, or Lo			4c. Count	y of Death	
_			Brook Grove Nursing Home 5. Social Security Number 6. Sex 7. A	ige (In yrs. last birthday)	Sandy Spring    Sandy Spring   Sandy			Date of Birth		gomery lace (State or Foreign
	Funeral Director		577-38-0550 1□M 2図F	81 Yrs.		Hours Min.	(Month, Da	y, Year)	Coun	try) ct of Columbia
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Maryla f shored ed at	0				C!-	_		'	1 ☐Yes 2 X No
	28a-	Director	Maryland Montgomery  10e. Street and Number		10f. Zip Code	ver Sprin	g	10g. Citizen of	What Coun	try?
	h with	a D	3005 South Leisure World Blv	d #401		20906			U.S.A	E
	ems 2	Funeral	11. Marital Status 12. Was Deceder Armed Forces		Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Sp Mexican, Puert	pecify Yes or No Bican, etc.)	- 14. Ra	ice - Americ	an Indian,
2	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐	No		Specify:		Speci		210.
5	hour tural'	ed b	3 X Widowed 4 □ Divorced Year or Dates  15. Decedent's Education		dent's Usual Occupati	on		16b. Kind of E		White
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Ž	2 should to and Ment Is marked aumatic	2	William Kuffner				Agnes Mar			
<u> </u>	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street an			er, City or Towr	n, State, Zip	Code)
ב ע	1 and 2 Health Iem 27 I		William J. Whelan - Son  20a. Method of Disposition		Ashton Road, osition (Name of matory or other place)		Maryland Date	20861 20c. Location	- City or To	wn State
5	Pages nent of h int: If Ite		1 m Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	e	matory or other place) aven Cemetery	a .	26/2008		-	
	그 두 약 글		21. Signature of Funeral Service Licensee	2	2. Name and Address	of Facility			hr rug,	Maryland
בֿ	permi Depar Impor any Ir		I aloj Warne		ines-Rinaldi 1800 New Hamp	Funeral H shire Ave	ome, Inc.	er Spring	g, Mary	1and 20904
F			23a. Part1. Enter the dise se, o complications that caus shock, or heart failure. List any one cause on each							Approximate Interval Between
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9	/Medical Examiner		resulting in death)  Due to (or a	s a consequence of):		$\cap$		am	mr	
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				N. S. S.		0/	
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	tificate be executed g physician and as the burial-transit	edical			~		7 .	2		
)		Mine.	IF FEMALE:	*			1	1		
ה מ	eath cer attendin for use	ian/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	Ectopic pregnancy				ate of delive	ery Day Year
;	y the a	Physician/N	1 ☐ Yes 2 🗷 No 4 ☐ Fregnant 9 ☐ Unknown 9 ☐ Unknown		Other (specify)					•
1	w requires that the deben signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	ınderlying cause given	in Part I.	23e. Did t	obacco use cor	ntribute to th	ne cause of death?
25	quires en sign uld be	q pe	Left Leg Tibeal Plateau Fractu	ıre			10	Yes 2. No	3 ☐ Prob	ably 4 Unknown
ט ט	law re as bee 2 sho	plet					24a. Was		. Were auto	psy findings available mpletion of cause of
	The ate h	Completed					autoj perfo 1∐ Yes	ormed?	death?	
ם ב	certific ector,	Be	25. Was case referred to medical examiner?				th (Check only o	опе)		
5	Phys this ral dir	. 10	1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpa  27. Manner of Death 28a. Date of Ir			4 Nursing H	ome 5 Resi			/)
5	Attending Physician: The law requir ar death. ecorth: After this certificate has been si by the funeral director, page 2 should by the funeral director, page 2.	tion		Day Year) Injury	Work?	es 2. ANo	28d. Describe how injury occurred  Subject tripped over a curb.			
2	Atter r deal ector by the	ifica	3 Suicide 6 Could not be 28e. Place of i	njury - At home, farm, st			28f. Location (	Street and Num	nber or Rura	I Route Number,
5	tal or s afte al Dir ed in	Certification:	4 Homicide building, etc. (Specify)  Gas Station  3100 Oney, State State Olney, Maryland				Road			
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier  (Check only one)  1  Certifying Physician: To the besist on the design on the page of	of examination and/or in	th occurred at the time rvestigation, in my opi	e, date and place nion, death occu	, and due to the	cause(s) and n	nanner as s	lated. the cause(s)
	Fo the within for the comple	Mec	29b. Signature and title of contifier	stateu.	29c. License r	number		29d. Date sign	ed (Month,	Day, Year)
			1	ms	7 1	043202		July 2	4, 2008	3
	30		30. Name and address of person who completed cause of	death (Item 23a) (Type,	, Print)					
			Charlene Ozanne-Blankfard, M.D	<del>-</del>	Leisure Blvd.	., Silver	Spring, N	laryland	20906	
	Sta Registr		31. Date filed (Month, Day, Year) 22. Reging 22. Reging 23. Date filed (Month, Day, Year)	strar's Signature	the s					
	riegisti		JUL A T LUUO AND ALL	1 10 /2/2000						

DHMH 17 Rev 1/2001

			partment of Health and Nertificate of Death	lental Hygie	0
Physici /Medic		1. Decedent's Name (First, Middle, Last) LYNDA WILSON		2. Date of Death Month	Day Year 08 0045 M
Examin		4a. Facility Name (If not institution, give street and number)  3432 Hazelwood Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	4b. City, Town, or Location of Death  Edgewater  av) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	4c. County of Death Anne Arundel
Funeral Director		228-35-3033	Months Days Hours Min.	10/07/19	9. Birthplace (State or Foreign Country) New York
the Marylar 28a-f show notified at	rector	10a. State   10b. County   10c. City, Town or		100	10d. Inside City Limits 1 ☐ Yes 2 No  3. Citizen of What Country?
th with 23a or st be	al Di	3432 Hazelwood Road	21037		nited States
be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural" or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto     □ Yes 2 No Specify:	pecify Yes or No- pecify Yes or No- No- No- No- No- No- No- No- No- No-	14. Race - American Indian, Black, White, etc.  Specify: White
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once.	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired) emaker	king	Sb. Kind of Business/Industry Home
Mental Hyg arked othe	To Be C	17. Father's Name ( <i>First, Middle, Last</i> ) Antoine Kanakry	18. Mother's Nam Gladys A	e (First, Middle, Ma shroawe	aiden Surname)
ind 2 shealth and 27 is mer traum			ailing Address <i>(Street and Number or Ru.</i> 2 Haze1wood Road,E		
ages 1 ant of Hear		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, or completely and completel	sposition (Name of crematory or other place)	Date 20	Oc. Location - City or Town, State
permit. Parameter Permit. Parameter Important any injury once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service (Cornee	Memorial Garden 107/24 22. Name and Address of Facility Ge 2973 Solomons Isla	orge P. K	
Physician /Medical					
Examiner		Due to (or as a consequence of):  Sequentially list conditions,	,		,
te be executed ysician and le burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
icate be physicia the bu		d			
The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the the things of the the things of the the things of the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the cause of death?  2☐
	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
rsician s certifi lirector	o Be	25. Was case referred to medical examiner?  1   Yes 2   No	Othor:	th (Check only one)	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	ation: To	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	e of 28c. Injury at	28d. Describe how	ce 6 □Other (Specify) r injury occurred
tal or Att rs after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
the Hospi hin 24 hou the Funer apletely fill	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dependence on the basis of examination and/condition and manner stated.	r investigation, in my opinion, death occu	, and due to the cau rred at the time, dat	ise(s) and manner as stated. te and place, and due to the cause(s)
To To	Σ	29b. Signature and title operation	29c. License number 0 21438	.   9	d. Date signed (Month, Day, Year)  Wy 21, 2008
le ICH		30. Name and address of person who completed cause of death (Item 23a) (Ty	PEPENSE HIGHW	AY ANNI	APULIS MOLIYOI
Sta Registr		31. Date filed (Month, Day, Year)  JUL 2 2 2008  32. Polistrar's Signature	Louis .		
HMH 17 Rev 1/2	001		7-10		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 3357 PM 2008 <u>Charles Eugene Wicks</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Center WICOMICO 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 ☐ F Director 214-28-8109 29, 1933 June Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified Director 1X Yes 2 No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ö 23a 6314 Hardwood Drive Funeral 20706 USA items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 53 — 155 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married ō 2 1 ☐Yes 2X No Specify: 3 Widowed 4 Divorced 2 should be filed within 72 hours and Mental Hygiene.

is marked other than "natural", Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator 5+ Education Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Stetson M. Wicks Laurstina Hormand 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s
Department of Heath ar
Important: If item 27 is
any Injury or other trau 6314 Hardwood Drive Lanham, MD 20706 Jean Gillard Wicks/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 7/23/2008 | La Grange, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home aller 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician Cardiovoscular discard teriosc1 ero tic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a o 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ď. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 autopsy certificate 2 **Z** No 1 ☐Yes 2 ☐No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**/**ŽNo Hospital: After this funeral dir 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Gun D54807 July 16, 2008

State Registrar 100€.

SAlisbury Md 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGARWAI

2

RAMESH

31. Date filed (Month, Day,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Damon 2008 Woolford /Medical 10:20 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson <u>Baltimore</u> Social Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs, last birthday) July 13 2 **Funeral** Birthplace (State or Foreign Country) 217-94-6768 1**X**M 2□F Months Days Hours 2008 Maryland Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MDRandallstown Balt More with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2113 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 INo þ Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 12 should be filed within 72 hand Mental Hygiene. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Woolford Kowana 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Byxbee permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra Damon Rd. Randallstown, MD. 21133 Woolford 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 ☐ Cremation Field 7/26/08 Church Creek, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Fine) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** <u>Sepsis</u> Hours /Medical Due to (or as a consequence of): Examiner Prematurity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hours Due to (or as a consequence of): Examine be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ※ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ↑▼ Yes 2 □ No 24a. Was an autopsy Yes Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home ٩ 1 ☐ Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural Natural 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760 P.O. Records, Division or Vital or Attending Hospital

> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who come

31. Date filed (Month, Day, Year) JUL 2 3 2008



vanon ru

eted cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D30206

29d. Date signed (Month, Day, Year)

7/15/2008

21204

2008 25530

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jeffrey Adrion Alston 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Adrion Alston, II Decedent's Name (First, Middle, Last) Jeffrey Physician/ Month Day August 5, 2008 0111 hrs J Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** University Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Davs Hours 17-08-8484 Director Country) Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No or items 23a or 28a-f sho must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10g. Citizen of What Country 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black. Funeral 12. Was Decedent Ever in U.S. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 Married 2 X No Yes Yes 2 No specify: Divorced If Yes, Give Year ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Indust 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) is marked other than 'atic event, the Medical nemployen made 17 Father's Name (First, Middle, atricia Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code ပ္ item 27 Date 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 2 Cremation 3 Removal from State Lion Important: Other Specify 22. Name and Address of Fac pproximate Interva er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician Between Onset and st only one cause on each line. **Medical** Death Multiple Gunshot Wounds Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last that the death certificate be executed attending physician and or use as the burial - trans Physician/Medical #1, per ME, g883 8/16/08 TT AMENDED UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ğ 1 Yes 2 V No 3 Probably 4 Unknown σ. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? certificate has performed? Nο 1 V Yes ✓ Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 V Yes 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject shot Aug 5, 2008 0032 hrs Division Natural 1 Yes 2 ✔ No Pending Director: d in by the f Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 1700 West Fayette Street, Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 5, 2008 O.C.M.E , nor

State Registrar

Ling Li, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Segistrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. "AMEND TIEW#26, perPHYS, G882,8/8/08, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4, 2008 5:55 P M Robert Lee Allen August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8 Harden Ave. Owings Mills Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 19,1932 9. Birthplace (State of Country)
Missouri Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours XXM 2 F 494-32-6148 76 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes XXNo Director MD Baltimore Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 8 Harden Ave. 21117 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married Married 1 □ Yes XX No altimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Superintendent Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Darrel W. Allen The1ma Hubbard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Harden Ave. Owings Mills, MD 21117 Department of Health Important: If Item 27 any Injury or other tronce. Jane A. Allen / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/8/08 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Puneral Service Licen relie Janua 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** oronary /Medical Due to (or as a consequence of): Diabetes Melli Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Amen's cleroses burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Ischemic Cardion Physician/Medical attending p for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No Prostek Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient — Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Tes 2 No CR/Gutpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 5 ☐ Pending investigation 1 Natural
2 ☐ Accident after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Legislation of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D23679 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Kenneth L. Glick mb. 10755 Falls Road Smite 200 Lutherville Meryland Smite 200

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0

2008

8

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 05:17 AM Mohamed 04 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Days Hours Yrs Sudan 11 01 Director 387-06-4243 58 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10a State 10c. City, Town or Location at Y Yes 2 □ No Director or than "natural", or Items 23a or 28a-f s the Medical Examiner must be notified NA Baltimore MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21244 11 East Bend Ct. Apt Funeral U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates: 2 NO 1 ☐ Yes 2 No Specify Black <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
Int: If item 27 Is marked other than Pactel Company 2th grade Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aljudalia Idrs Mahmoind Ali 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt F, Baltimore, Md East Bend Ct. Alyan Ali-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 8/5/08 Woodlawn, Md 21. Signature of Funeral Service Licensee регтіт. 22. Name and Address of Facility March F/H West ERUPL + I Nompson 4300 Wabash Ave, Baltime Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part 1 shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis

Due to (\*r as a consequence of): **Physician** one week /Medical emophagocytic syndrome Examiner three months Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year ŏ in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the att Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/No 3 🗌 Probably 4 🗌 Unknown 1 ☐ Yes Completed peen s Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4  $\square$  Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 ☐ Yes P After this completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: (Month, Day 1 Natural 2 Accident 5 Pending investigation Injury 2 □ No 1 Tes 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only

The law requires that the death certificate be executed of Vital Records, P.O. Box 68760, Physician: Division or Attending 24 hours after death, Funeral Director: At Hospital To the I within 2

3altimore, Maryland 21215-0036

State

Registrar

DHMH 17 Rev 1/2001

one)

Kendra

31. Date filed (Month, Day, Year)

and manner stated

medical rson who completed cause of death (item 23a) (Type, Print)

> ohns 32. Registrar's Signature

HOPKINS

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 03 Physician 09:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Baltimore MD VA Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 □ M 2√ F 59 Director 243-82-4811 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9620 Brie Court 21133 USA . Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc within 72 hours after 1 Tyes 2 □ No
If Yes, Give
Year or Dates: 1968-71 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No SpecifiAfrican-American Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supply Specialist VA Medical Center 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i 2 should be fi h and Mental h Monroe Torain Mary Maggie Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum Francell Allen/Husband 9620 Brie Court, Randallstown, MD 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Take View Memorial Sykesville, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service License 9200 LibertyRoad, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** 3 day /Medical Due to (or as a consequence of) Examiner Multiple Sclensis Sequentially list conditions, if any, loading to infine flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Due to (or as a consequence of): Box 68760 death certificate be Physician/Medical as attending IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) P.0. ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient မ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1 Natural (Month, Day Year) Injury 5 Pending To the nospius after death.

Within 24 hours after death.

To the Funeral Director: Aft М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) medical Resident 108 XI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State 31. Date filed (Month,

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L.

Day, Year)

32 Registrar's Signature

16 S. Eutaw Street Baltimore, MD 21201

Pleasa Type or Printin Black Indelible 18k8 Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 7/9AM **Physician** -00M une 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard **Howard County General Hospital** 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2 F Director 83 MD 212-20-2616 May 15, 1925 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Director MD Columbia Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be in 10799 Hickory Ridge Rd. 21044 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 ih and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Sales Bakery 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ William S Martin Eva R. Jordan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health an
Important: If them 27 is r
any injury or other traur 2308 Rockwell Ave., Catonsville, MD 21228 William Bloom 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) Aug 07, 2008 Timonium, Maryland **Dulaney Valley Memorial** ignature of Fun, al Service Licer 22. Name and Address of Facility ternell & Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 11100531 Part1. Enter the diseas shock, or heart failure. Approximate
I Between
Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. ediate Cause (Final Physician Third digree ease or condition sulting in death) /Medical Due to (or as a consequence of): Examiner Athenoscientic Cardivincular distuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ENTERIOR APPRIED BY MEDICAL ELIMINES attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Day Year 5 ☐ Other (specify) 0 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by thrombosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown (D) ankle 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy perform Respiratory tailury certificate or Attending Physician; 25. Was case referred to medica examiner?
1 ☑ Yes 2☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer Division Injury 700 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗷 No ours after death.
neral Director: A 2 Accident trom Standing 6 ☐ Could not be 10 Location (Street and Number or Rural Roule Number, 2004 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hours of To the Funeral To the Hospital 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aug 4,2008 mos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Am 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DHMH 17 Rev 1/200

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** Alexander Bogomaz 2008 11:00p August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Care Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 217-38-5125 70 Director Poland 5 1937 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 'natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD Carroll Mt. Airy Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene.
ant: If them 27 is anarked other than "natural", or Items 23a or 28aunt or other traumatic event, the Medical Examiner must be notifi 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4365 Ridge Road 21771 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) insurance insurance supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Demjan Bogomaz Vera Wier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline Bogomaz (spouse) 4365 Ridge Rd., Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. View Cemetery 8-9-08 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Dage Hargert o P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Accemda Immediate Cause (Final Cerebro **Physician** Da disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 25 No ဥ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation neral Director: / 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Registrar

0

31. Date filed (Month, Day, Year) State

Sacra

29b. Signature and title of certifia



MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Card

TOLL

29c. License number

D43091

29d. Date signed (Month, Day, Year)

8-6-08

House Ave, Frederich, MD 21711

			For State Registrar	of Maryland / Dep	partment of Health and M ertificate of Death		2008	25536
			Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physici /Medic			WNER		August	5,2008	2247 M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and results of the	2.1	4b. City, Town, or Location of Death  Clin Ton  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) APRIL 25	(ear) Co	h Cerqs  hplace (State or Foreign unitry)
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Maryla	ō	MD PRINCE GEORGE'					1  Yes 2 □ No
	r 28a	rec	10e. Street and Number	5   TEMPLE H	10f. Zip Code	100	g. Citizen of What Co	untry?
	th witl	ai D	4202 CARRIAGE DRIVE		20748		USA	
50	s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Heelth and Mental Hygiens. Item 27 Is marked other than "naturel; or Iteme 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	Amed	Forces? s 2 X No Sive	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
200-	2 hou		15. Decedent's Education	16a. Dec	cedent's Usual Occupation	16	Sb. Kind of Business/	
21212	filed within 7. Hygiene. ther than "n int, the Medi	Completed	(Specify only highest grade complete Elementary/Secondary (0-12)  College 2 YRS	(1-4or 5+)	ive kind of work done during most of work b. DO NOT use retired) NISTRATIVE ASSISTA	C	ONSUMER H	EALTHCARE
and	be filed ital Hygi od other event,	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma	aiden Sumame)	
7	2 should be and Mental le marked c	ဥ	JOHN RANDOLPH TAPSCOTT  19a. Informant's Name/Relationship (Type, Print)		GERALDI.	NE SMYRE	City or Town State	Zin Codel
<u>8</u>	and 2 seelth an m 27 le i		JOSEPH A. BRAWNER, JR/				LLS, MD 2	
Hore,			20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	20b. Place of Dis cemetery, c	sposition (Name of rematory or other place)	Date 20	Oc. Location - City or AUREL, MD	
Dalt	permit. Page Department of Importent: If any njury or once.		21. Signature of Funeral Service Micensee  DON		22. Name and Address of Facility MA: 4308 SUITLAND ROAD		FUNERAL HOLL	OME OF MD 20746
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of	t caused the death. Do not en each line.	enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
			Immediate Cause (Final disease or condition resulting in death)	Myocara	dial Infarc1 Perotic Cardio	10.0		Onset and Death
			Due	to (or as a consequence of):	Pertie Cardin	terr. le	1 He #	Dreese
		ler	if any, leading to immediate Due:	to (or as a consequence of):	erblic caree	as any a	O HEEN	
,	cuted nd ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):					
8/00,	cate be executed physicien and the burial-transit							
200		edicai	d					
.O. BOX	wrequires that the death certifi been signed by the ettending should be deteched for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown		23d. Date of del Month	ivery Day Year		
cords, P	requires that the peen signed by th hould be deteche	þ	Part II. Other significant conditions contributing to	death but not resulting in the	e underlying cause given in Part I.			the cause of death?
2	The lar	Completed				24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of 2 No
Vita	Physiclen: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examined?  Hospital:		Othor	th (Check only one		
ō	Phys er this eral di	5.7	27. Manne of Death 28a. Da	☐ Inpatient 2 ER/Outpat te of Injury 28b. Time	e of 28c. Injury at	ome 5 Residen 28d. Describe hov	ce 6 Other (Spe vinjury occurred	cify)
0	ath.	ation	1 □Natural 5 □ Pending (M 2 □ Accident investigation	onth, Day Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No			
DIVISION	tal or Atters selected Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Pla bu	ace of Injury - At home, farm, ilding, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attending Physicien: within 24 hours elter death. To the Funerel Director: After this certific completely illed in by the funeral director.	edical	(Chack only 22 Medical Examiner: On the	bacie of avamination and/or	path Jeeurred at the thire, date and place, investigation, in my opinion, death occur	rod at the time, det	a and alone, and due	to the equec(e)
	To t Com	Σ	29b. Signature and title of certifier	eto on	29c. License number	29	d. Date signed (Mont	th, Day, Year)
	0		Salvodor /gt	700 90	1900559	-( )	rugus 73	1000
			30. Name and address of person who completed completed by Sylva Completed Completed Completed Completed Completed Completed Complete Compl	ause of death (Item 23a) (Type 300) Ho	29c. License number  1500 559 5  De. Print)  Spital Drive,	Lever	4 MAY	gland
	Sta Regist		AUG 0 8 2008	ele to the	uli			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 25537 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician**  $\mathbf{P}^{\mathsf{M}}$ Broccolina August 5 2008 1:13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-46-7356 61 MD Director Jan 16, 1947 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 4018 Pebble Branch Rd. 21042 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Examiner filed within 72 hours after 1 Never Married 2 Married , o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Specify: 3 Widowed 4 Divorced Year or Dates: "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ed other than "nature event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **Registered Nurse** Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental **Donald Oettinger** Hilda Kuhl ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Dario Broccolino 4018 Pebble Branch Rd. Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory, LLC Aug 08, 2008 Glen Burnie, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility lallan Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Mcc 535 a. art 1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis 1 day Medical Examiner Due to or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Brain Completed 1 TYes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Ýes 2 No 1 Tes 2 🗌 No Division of Vital Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury after death. 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, à 4 Homicide City or Town, State) 24 hours 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title August 5,2008 D0066613 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph D Jordan, MD 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Maryland / De <i>C</i> e	partmer e <i>rtificat</i>			nd Ment		0 0	008	2553	8
	Physici		Decedent's Name (First, Middle, L.	Larr					N	ate of Deat	th Day	Year 2008	3. Time of Death	ا
4	/Medic Examir	er	4a. Facility Name (If not institution, gi		or)	1	, Town, or	Location of D			4c. County			
	Funeral Director		5. Social Security Number 6.		Age (In yrs. last birthda Yrs.	y) If Unde	r 1 Year	If Under 24	Min. (A	ate of Birth Month, Day,	Year)	9. Birthpla Countr	ace (State or Foreign y) MD	
	f show	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or							10	od. Inside City Limits 1 X Yes 2 □ No	-
	with the N la or 28a-	Director	MD  10e. Street and Number	N/A	B <u>altim</u>		o-Code	21	229	1	0g. Citizen of V	Vhat Countr		-
9	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. Its marked oither then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funerai	272 S. Loudon  11. Marital Status  1    ↑	12. Was Decede Armed Force 1  Yes 2	es?	3. Was Dece If Yes, spe		spanic Origin , Mexican, P		es or No- , etc.)		S A e - America ck, White, et		+
Maryland 21215-0036	72 hours a 'natural", dicel Exan	eted by	3 Widowed 4 Divorced  15. Decedent's I (Specify only highest g.	Year or Dates Education	16a. De	cedent's Usu	ork done di	Specify: tion uring most o	of working _	- /-	Specify 16b. Kind of B	Bla		-
12121	filed within Hygiene. ther then ' mt, the Me	Completed	Elementary/Secondary (0-12)  N/A  17. Father's Name (First, Middle, Lasi	College (1-4 o		e. DO NOT u	ise retired)			N/A	Maiden Suman	ne)		
ıryland	s 1 and 2 should be filed with if Health and Mental Hygiene. Item 27 Is marked other ther other traumatic event, the M	To Be	Larry Barksda	le, Jr	19b. Ma	ailing Addres	l	Deni	se Sn	nith	r, City or Town,		Code)	_
	s 1 and 2 s f Health ar tem 27 ls other trau		Denise Smith- 20a. Method of Disposition	Mother		S. I	Coudo	on Av		Bal	Lto, M.	D 212	229	
Ë	it. Page ntment o rtant: If njury or		1 ☐ Burial 2 ☒ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Special Service Lice	ify)	Greenm		Cen	n   8.		2008E	Baltim	ore,		
Ä	Depa Depa Impo any I		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	ipplications that caus	sed the death. Do not e	110] enter the mo	E de of dying	Nort	h Ave	nue	F/H E. Balto est,	MD 2	21202 Approximate	_
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Con	O E NITA as a consequence of):		PART	-	SEAS				Interval Between Onset and Death	
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or	as a consequence of):					_				_
8760, ST	cate be executed physician and s the burial-transit	EX	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a consequence of):							-		_
687	tificate ig physi as the	Medical	IF FEMALE:	d										
O. Box	Attending Physician: The law requires that the death certific are death.  **re death.** **reteath.** **reteat		23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown		2 Fetal death tat time of death	3 ☐ Ectopic   5 ☐ Other (s)						te of deliver	y Day Year	
Division of Vital Records, P.O.	luires that the signed by all be detacted.	þ	Part II. Other significant conditions	contributing to deat	h but not resulting in th	e underlying	cause give	en in Part I.	2	23e. Did tol		-	e cause of death?	
Reco	The law requires that ate has been signed page 2 should be de	Completed							_	4a. Was ar autops perform	y ned?	Were autop prior to com death? 1  Yes	sy findings available pletion of cause of	
Vita	sician: The certificate irector, pa	Be	25. Was case referred to medical examiner?	Hospital:			Other	26. Place of	Death (Che	ck only one	e)			
on of	To the Hospital or Attending Physician: whin 24 hours after deals are this certification to the Funerel Director; After this certification that the funeral director, and the funeral director.	tion: To	1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L	njury 28b. Time	of 2	28c. Injury Work?	at Nursir	28d. D		ence 6 - Oth			_
	al or Atten s after deaf I Director: d in by the	ertification:	3 Suicide 6 Could not determined	pe 28e. Place of	injury - At home, farm, etc. (Specify)	street, factor			28f. Lo	ocation (Si ity or Town	treet and Numb , State)	er or Rural	Route Number,	
	the Hospital or hin 24 hours afte the Funerel Dir mpletely filled in	Medical C	29a. Certifier 1 Certifying P (check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manner	st of my knowledge, de s of examination and/or stated.	ath occurred investigation	at the time	e, date and p inion, death	place, and d occurred at	ue to the c	ause(s) and ma date and place,	anner as sta	ated. the cause(s)	
	Vithi To the	ž	29b. Signature and title of certifier				. License				9d. Date signed			
		-	30. Name and address of person who	completed cause			KE5	-00	0		AUGUS	r 6	2008	_
	\		JUSTIN LOCK 31. Date filed (Month, Day, Year)	MAN, MD	strar's Signature			60	00 Nort	th Wol	fe St, Ba	Itimore	e, MD, 2128	7
	Sta Registr			0.000	strar's Signature	mark.	3							

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE REHABI EXTENDED TATION Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Min. Months Days Hours 1**X** M 2□ F 215-42-8346 3/ 1944 Director MD Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Peologic Examiner must be not flind at Perry Hall MD Baltimore 1 ☐ Yes 2 X No Director the ! 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 1 8927 Cowenton Rd 21128 U.S.A. death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Ite 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 Yes Give Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Frank Bruno Mary Rita Livolsi 19a. Informant's Name/Relationship (Type. Print)
Joseph Frank Bruno/Self 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8927 Cowenton Rd, Perry Hall, MD, 21128 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 8/9/2008 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr, Towson, MD, 21286 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PRIMARY SITE UNKNOWN Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) been signed by the should be detached ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 No 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Ar completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)
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2008

32. Registrar's Signature

ARD BALTINORE, MD , 2/2/8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Amend #2, perMD, g882 8/18/08 TT Certificate of Death Reg. No. 2 25540 Decedent's Name (First, Middle, Last) 2. Date of Death 8/4/2008 3. Time of Death Physician Baker Jr. Cornelius /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimure HOSPITAL OF Himure If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 78 Director 245-54-3424 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show injury or other traumatic event, the Modical Examiner must be notified at Director 1 XYes 2 No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 21207 U.S.A. 3727 Oakmont Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ò Be Completed by 1 ☐ Yes X☐ No Specify: Specify. 3 Widowed 4 Divorced Black "naturai", 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Melter Steel Factory 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Johnson Cornelius Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau 4979 Edgemere Ave, Baltimore, Angela Baker-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/10/08 Conetoe, Conetoe Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as eardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 200 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 24a. Was an autopsy certificate 2 VINo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one examiner: 1 ☐ Yes 2 No Other: Aursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending Injury 1 ☐Yes 2 ☐ No hours after death. illed in by the f investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier pletely and manner stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 15 Year) 2008 32. Registrar's Signature 31. Date filed (Month, Day, State 8 AUG 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 23a PtI, II per dering 282,08098/198dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 16 JUN & /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYIMUNE, MO 2137 408 PITAZ SECVUMS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Year)
9. Birthplace (State or Foreign Country)
1930 HORTH (ARDLINA 6. Sex Funeral 1 □ M 2 🛛 F 78 219-26-1900 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural". or itema 23a or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Important: If Item 27 Is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at Director BALTIMORE 1⊠Yes 2 No MARYLAKUD 10e. Street and Number 10g. Citizen of What Country? STRICKER Funeral Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 No Specify Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DWN HOME ITH GRADO HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BRUCE ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOSEPH E. CLIFTON JR. (SON) 15 N. STRICKER ST, BALTIMORE, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK DE-OI-2008 BALTIMORE, MARYLAND 22. Name and Address of Facility

503EPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE, BALTO, MD 21217 21. Signature of Funeral Service Licensee ichich N. W Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOGENIC **Physician** disease or condition resulting in death) ) /Medical Examiner Massive Myocardial Infarction 3 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) ed by the a 9 Unknown signed by the land Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anoxic Encephalopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been signal, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural ie Funeral Director: A pletely filled in by the fi 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completely f Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

2000 W. Baltimore St. Baltimore, md. 21223

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

EVIC MARCOUNI
31. Date filed (Month, Day, Year)

AUG 0 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1840 M AUG 2008 Lois A. Crowl 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOSPITAL BALTIMORE AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/27/1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland Days Min 1 □ M 2 □ N 87 Director 216-32-6735 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f shor other traumatic event, Ite Medical Examinan must be notified at 1 ☐ Yes 2 XNo Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 North Hilltop Road 21228 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 No White Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi Howard Clem May DiMartello ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 101 South Rolling Road, Catonsville, MD 21228 Edward R. Crowl (Son) Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If Its any Injury or o ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery: 08/11/2008 Baltimore, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatur of Funeral Service Licenses Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ELONEPHRITIS **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner ENYDRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical as I IF FEMALE: asn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy ō in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 ☐ Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ATRIAL 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has page 2 perform certificate } Division of Vital 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After this 27. Manne of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0054257 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.S.M.A.R.M.A. S.T. A.G.N.E.S. F MOSP. BALTIMORE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Clark Herbert 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital N/A Baltimore Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 ₹ M 2 ☐ F MD 220-14-2922 Usual Residence of Decedent 84 3-22-1924 10d. Inside City Limits 10b. County 10c. City, Town or Location Y□Yes 2□No N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number S 21218 Α 325 E. 21st Street 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. Specify: Black 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th grade Ń/A Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hester Parker <u>Alexander Clark</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 325 E. 21st Street Balto, MD 21218 Pauline Lewis-Stepdaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Pk 8-9-2008 Randallstown, MD 21. Signature of Funeral Service Usensee 22. Name and Address of Facility March EAst F/H 21202 North Avenue Balto, 1101\_E. 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PROSTATE ADENOCARCINOMA Unknown Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

Funeral

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Completed

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinar 1 and the multified at

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Examine the Hospital or Attending Physician: The law requires that the death certificate be executed in 34 hours after death attending physician and for use as the burial-transit Physician/Medical After this certificate has been signed by the a funeral director, page 2 should be detached in <u>۾</u> Completed Be Certification: To after death.

Director: Af
d in by the fur

Immediate Cause (Final resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Natural 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of contine 29c. License number

State Registrar

Medical

DHMH 17 Rev 1/2001

24 hours af E Funeral Di letely filled in

within 2 To the I

completely

30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

6821 32. Begistrar's Signature

S. Salvic Ma

8

AUG 0

31. Date filed (Month, Day, Year)

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Neisturton NZ BEIL MD SIZIE

801418

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 25544

State of Maryland / Department of Health and Mental Hygiene

			For State	-	Certifi	cate of	Death				Reg. No.			
1	Physicia		. Decedent's Name (First, Middle,	Last)						2. Date of Do Month	eath Day	Year	3. Time of Deat	h
i	Examir		Willie	1	Lewis		Ca	meror	1	August 3	3, 2008	1 Cai	1918 hrs	
			a. Facility Name (if not institution,			4	b. City, Town,	or Location	of Death		40	. County of	Death	
			Sinai Hospital			1	Baltimore							
	Funeral		5. Social Security Number 6	. Sex 7. Age	(In yrs. last t	oirthday)	If Under 1 \	ear If Und	er 24Hrs.	8. Date of	Birth (MM	/DD/YYYY)	9. Birthplace (State or	Foreign
	Director			1X M 2 F	56	Yrs.	Months E	ays Hour	Min.	05	12	52	Country) SC	-
				M Z F	50	115.	1		<u> </u>					
	è	_	Usual Residence of Decedent  10a, State  10b, County		10c. City, Tov	wn or Locatio	on						10d. Inside City	Limits
h	w ag		,	ia l		Balti							1 X Yes 2	No
1	Aaryland 28a-f show any 1 at once.	ē.		A .							10a Cit	izen of Wha	at Country?	
$\mathbb{C}$	Mary 28a- d at	Director	10e. Street and Number				10f. Zip Cod				Tog. Cit			
2	the la or		2603 Ulman Av	'e				21215			<u></u>		S.A.	
/	death with the Maryland or items 23a or 28a-f sho must be notified at once.	ᇒᅵ	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		Decedent of				No-	14. Race - White,	American Indian, Blac etc.	k,
	leath r ite	Ξĺ	1 Never Married 2 X Mar		X No									
	fler (		3 Widowed 4 Divor	rced If Yes, Give Year		1	Yes 2 X	No specify	: 			Specify:	Black	
	hours afte 'natural'', Examiner	d by	15. Decedent's Education (Speci	fy only highest grade com	pleted) 16		st Usual Occi				16b.	Kind of Bus	iness/industry	1
	72 ho	황	Elementary/Secondary (0-12)	College (1-4 or 5	(+)	aunng me	ost of working	ine. DO NO	usereui	eu)	-			1
	thin than the	림	9th grade	na		Set	up Ma	an			Lo	ck I	nsulater	
	5-0036 led within 72 tygiene. other than the Medical	Completed	17. Father's Name (First, Middle, L	ast)				18.Mothe	r's Name	(First, Middl	e, Maider	n Surname)		
	e file	Be (	Lee Cameron					Geo	rgia	nna (	Gait	her		
	21215-0036 uld be filed within 72 hours af Mental Hygiene. marked other than "natural c event, the Medical Examin	- B	19a. Informant's Name/Relationsh	ip (Type, Print )		19b. Mailing	Address (S	treet and Nu	mber or F	tural Route I	Number, (	City or Town	n, State, Zip Code)	
	MD 21215-0036 12 should be filed within 72 hours after death with the Maryland tith and Mental Hygiene. 127 is marked other than "natural", or items 23a or 28a-f she timatic event, the Medical Examiner must be notified at once		Rebecca Camer	con-Wife		2603	Ulmar	a Ave	, Ва	ltime	ore,	Mđ	21215	
	and and tem	-	20a. Method of Disposition				ition (Name o	f cemetery,		Date	20c	Location -	City or Town, State	
	Ore Ses 1 of H		1 X Burial 2 Cremation	3 Removal from Sta	ate crer	matory or oth	carme	a 1	8/9	80\	l <sub>B</sub>	alti	more, Md	
	Pag ment tant:		4 Donation 5 Other Spe							, 00				
	Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other tranmatic event, the Med	1	21 Signature of Funeral Service L	1		Mar	ame and Add	H We	st					_
1		$\perp$	23a. Part I. Enter the disease, or o	thom pru	U - L-W D	<u> 430</u>	00 Wal	<u>bash</u>	Ave	Bal.	cimc	ore,	Md 21215 art Approximate	
	ysician		23a. Part I. Enter the disease, or of failure. List only one cause of	on each line.							arrest, si	lock, or fied	Detween On	set and
	/Medical Examiner		Immediate Cause (Final disease	a Atheroscl	erotic	card	iovasc	ular d	isea	se			Deat	n
	LAdilliles		or condition resulting in death)	Due to (or as a cons	equence of):									İ
			Sequentially list conditions,	b								-		
		ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of):									l
		Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):									
	xecuted n and - transit		events resulting in death) Last	d.						_				
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	760, icate be exe	e e	IF FEMALE:	23c. If yes, outcome	me of pregna	ncv					1 2	3d. Date of	delivery	
	68760, certificate be nding physic se as the buri		23b. Was decedent pregnant in the		no or program	2 Fe	etal death	3 Ecto	oic pregna	ancy		Month	Day Y	'ear
	leath certifu e attending for use as t	cia	past 12 months?		time of death	•	ther (Specify)				.			
	Box e death c the atten ed for us	ıysi	1 Yes 2 No 9 Unk	o o.m										
	O. lat the d by t	by Physician	Part II. Other significant conditi	ons contributing to deal	h but not resu	ulting in the i	underlying ca	use given in	Part 1.				ibute to the cause of de	1
	es the	5	Cocaine use							1	Yes 2	No 3	Probably 4 V Ur	nknown
	ords, w requir s been s	Completed									Vas an	24b. \	Were autopsy findings prior to completion of ca	available
	SOF law r has b	힐	·							P	utopsy erformed	? 6	death?	_
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	tal Recian: The certificate ector, page	Be (	25. Was case referred to medical examiner?	It to a state of				Other						-
	Vit hysic this	10	1 ✓ Yes 2 No	1	ent 2 🗸 E					ng Home 5		dence 6	Other:	
	Division of Vital Records, P. tat or Attending Physician: The law requires the ris after death.  al Director: After this certificate has been signe led in by the funeral director, page 2 should be de		27. Manner of Death	28a. Date of Inj (Month, Day,		8b. Time of		. Injury at Wo	_	28d. Desci	ibe how i	njury occurr	red	
	ion tendi eath. tor: /	tio	1 X Natural 5 Pend	ling stigation			1	Yes 2	No					
	r Att rer de irect n by	fica		d not be 28e. Place of I	njury - At hom	ne, farm, stre	et, factory, of	fice building,	etc.		on (Stree		er or Rural Route Num	ber, City
	Divisi pital or At ours after d teral Direct	Certification:		mined (Specify)						01100	vii, Otate)			
	Hosp 4 hor Fune ely fi		29a. Certifier 1 Certifying Pt	nysician: To the best of m	ny knowledge	, death occu	irred at the tin	ne, date and	place, and	d due to the	cause(s)	and manne	r as stated.	
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Exam	miner:On the basis of exa	mination and	l/or investiga	ation, in my op	oinion, death	occurred	at the time,	date and	place, and o	due to the cause(s)	8
1	To To Too	Mec	29b. Signature and title of certifie	and manner stated	7		29c. L	icense numb	er		29	d. Date sign	ned (Month, Day, Year)	
-	d	_	10.1111	111/	1		0	C.M.E.			Α	ugust 4,	2008	
b	18 Jens		anout		1-01-12-12	130)								
	. 1		30. Name and address of person	who completed cause of Assistant Medical E	deaminer xaminer	.sa) 111 Pല	nn Street	Baltimore	. MD 21	1201				
						4	an Sueet,	- and the C	, IVID Z	.201				
	9	tate	31. Date filed (Month, Day, Year)	2008 3 Registr	ar's Signature	100	W. Co.					(	OCME	

Gregory Craven
08-05861 P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

2008 25545

Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD 10c. Street and Number 10d. City, Town or Location 10d. City or Code 11d. City or Code 11	thplace (State or gn unitry) D.C.  10d. Inside City Limits 1 X Yes 2 No
4a. Facility Name (if not institution, give street and number) 2003 East Laffayette  5. Social Security Number 578–72–1808  1	thplace (State or gn puntry) D.C.  10d. Inside City Limits 1 X Yes 2 No ntry?
2003 East Laffayette  Baltimore  5. Social Security Number  6. Sex  1	10d. Inside City Limits 1 X Yes 2 No ntry?
Funeral Director  5. Social Security Number  1. Age (iii yis, last oil thiday)  Yrs. Months Days Hours Min. 11–16–1952  Foreign Co.  10a. State 10b. County  10c. City, Town or Location  Baltimore	10d. Inside City Limits 1 X Yes 2 No ntry?
10a. State 10b. County 10c. City, Town or Location	1 X Yes 2 No ntry?
i M n/a Raltimore	intry?
106. Street and Number 107. Zip Code 108. Citizen of What Cou USA 108. Street and Number 21206 USA 108. Street and Number 109. Citizen of What Cou USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. White, etc. White, etc.)	rican Indian, Black,
12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc.)  14. Race - Amer	
Afr	/Industry
15. Decedent's Education (Specify only highest grade completed)  during most of working life. DO NOT use retired)  during most of working life. DO NOT use retired)	
To Father's Name (First, Middle, Last)  18.Mother's Name (First, Middle, Maiden Surname)	
Richard H. Craven  Katherine Blake  Richard H. Craven  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State	e, Zip Code)
Sheilah A. Craven/Wife 5516 Knell Avenue, Baltimore, MD 21206	
4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens e  22. Name and Address of Facility Wylie FuneralHome P.A. of B.	
Physician Medical Ameniner  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Undarrying Couse (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):  c.  Due to (or as a consequence of):	
The part of the pa	
AMENDED 23a,27,28a-f, perME, g882 8/11/08 TT    Standard   Standar	ery Day Year
Yes 2 No 3 Pr	autopsy findings available completion of cause of
Yes 2 No 1 ✓	Yes 2 No
25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Oth	ner: Scene
248. Was an autopsy performed? 1 ✓ Yes 2 No  25. Was case referred to medical examiner? 1 ✓ Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death 1 ✓ Yes 2 No  28. Date of Injury 28. Time of Injury 28. Injury at Work? 28. Describe how injury occurred  1 Natural 5 Pending  248. Was an autopsy performed? 1 ✓ Yes 2 No  25. Was case referred to medical examiner? 1 ✓ Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death 1 Natural 5 Pending  28. Time of Injury 28. Injury at Work? 28. Injury at Work? 28. Describe how injury occurred	
Natural 5 Pending Investigation 28. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  1 Natural 5 Pending Investigation 28. Could not be determined (Specify)  1 Natural 5 Pending Investigation 28. Location (Street and Number or or Town, State) 2003 E. Ave. Baltimore, 1	Rural Route Number, City Lafayette MD
24a. Was an autopsy performed?  1	tated.
Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to care and manner stated.  29d. Date signed (Nowledge)  29d. Date signed (Nowledge)  29d. Date signed (Nowledge)	
30. Name and address of person who completed cause of death (Item 23a)	3
Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 3. Registrar's Signature AUC 1. 8 2008	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 4, Day 2008 Year Physician 1:30 P Depkin Gertrude J. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Hart Heritage Estate Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2**本**F 048-03-6579 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evandara must be notified at 1 □Yes 2 No MD Harford Fallston Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1722 Angleside Drive 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural"; or items; any injury or other traumatic event, its invident Exercises. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 □ Yes 2XX þ Specify: 3 XX Vidowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Clerical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude A Gaines Richard Zimmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1722 Angleside Drive, Fallson, MD 21047 19a. Informant's Name/Relationship (Type. Print) Charles Depkin, Jr. (son) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 08/06/08 Bayview Crematory Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signatur of Funeral Service Licens 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Road, Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 'CRONSE **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) P.O. ed by the a signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a, Was an as l autopsy certificate 1 ☐ Yes 2 12 No To the Hospital or Attending Physician: After this certific funeral director, 1457512 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) CARE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation reral Director: A 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 1/2001

State

Medical

(Check only one)

29b. Signature and title of cettifier

31. Date filed (Month, Day, Year)

MO

SPARKS 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

39889

615 W. MALDHAILRO, BUJAIN MD. 21014

29d. Date signed (Month, Day, Year)

August 5, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Joyce Anna Dana August 4, 11:45a<sup>M</sup> 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carriage Hill Nursing Home Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours 94 04/26/1914 Director 334-01-2816 WI Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Intent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, he Medical Examinat has natified at any or other traumatic event, he Medical Examinat has natified at 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits WI Racine Racine Director 1 □Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8130 Crystal Drive 53406 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify à Specify 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Lewis White John Exilda Hackett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Dana / Son 8130 Crystal Drive, Racine, WI 53406 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. 1 Burial 2 ☐ Cremation 3 Removal from State Graceland Cemetery 08/08/08 4 ☐ Donation 5 ☐ Other (Specify) Racine, WI 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHIVCER disease or condition resulting in death) COLON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be deached for use as the buriat-transit Exami Due to (or as a consequence of): Physician/Medical phys. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔄 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ∐Yes 2 WANo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Yes 2 | **∑**4 | 0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Injury investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00057124 815108

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. Bao, 1 Suburban Hospital, 6800 Old Georgetown Road, Bethesda, 1 MD

Baltimore, Maryland 21215-0036

Box 68760, 2

P.O.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23art1,11,25,27,26a-f per me, g888,02/06/09dhb rar Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5 2008 **Physician** C. Carey Dewitt August 05 01:28 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗙 F 216-38-3062 68 Director /9/1939 MD Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f shov MD Baltimore Towson ns 23a or 28a-f sh must be notified Director 1 □Yes 2 KNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 Range Rd. 21204 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any lijury or other traumatic event, If a Mudical Evanination. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 X No Specify: 2 Specify: White 3 ☐ Widowed 4 🗖 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) X-Ray Technologist Private Sector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Edward Carev Margaret Stewart 19a. Informant's Name/Relationship (Type. Print)
Edward Hughes Carey/Brother 413 Range Rd., Towson, MD, 21204 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Chesapeake Crem. 8/8/2008 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann PA 21. Signature of Funeral Service Licensee MO1443 8717 Green Pastures Dr., Towson, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Thirden APPROVED BY MEDICAL EXAMINER

CERTIFICATION APPROVED BY MEDICAL EXAMINER Immediate Cause (Final Physician CANCER BREAST disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ Thermal Injuries with Complications 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 1 No 1 ☐ Yes Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ည 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of After 1 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 05/25/2008 2:17 1 ☐ Yes Ž No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059283 LNTERNIST AUGUST, OG, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8415 BELLONA LANE #216, TOWSON MD O. ADDO RICHARD M.D

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 25 per me 9882 08/15/08dhb Registrar Amend 31 per DVR g882 8/8/08 entificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 12:15 AM Ellen Jane 2, 2008 Dowling /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F 220-24-7254 79 Director 11/17/1928 MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b, County 10d. Inside City Limits If item 27 is merked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7824 Rockbourne Rd. 21222 Funeral USA Pages 1 and 2 sho led be filed within 72 hours after death nent of Health and Niental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ₽ 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Cashier Grocery Store Health and Nental Hygien em 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Robert Anderson Alice Rose Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trainonce. Ellen J. Richardson (daughter) 35 Guinevere Ct. Baltimore, MD. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 08/06/2008 | Baltimore, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, MD 21222 Dundalk, Inc. 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypovolemic Shock Due to (or as a consequence of): weeks Due to (or all a consequence of): DONOVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has buen signed by the attending physician and C. diff Colitis CERTIFICATION Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes Certification: To 1 hpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00066584 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. CHARLES MITESH TRAMBADIA BALTIMORE, MO 6701 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ▶ AUG 0 8 2008 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

08/05/08 04/0 AM

DAN BECK

LIZABETH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

31. Date filed (Month, Day, Year)

AUG 0 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 25551 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** August 104 AM 2008 landa M /Medical E Dward 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore Under 1 Year 1 If Under 8. Date of Birth (Month, Day, Year) 1/27/1948 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) Funeral Hours 1 □ M 2 💢 F Months Days Min. **Director** 219-52-6754 60 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21221 U. S. A. Funeral 420 Dorsey Avenue Pages 1 and 2 should be filed within 72 hours after death neath of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23 unty or other traumalle event, if it Me. Jical Exprinter nual 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify. þ 3 Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cromwell Shindledecker Margaret Norman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. <u>Jeffrey A. Edwards,</u> 420 Dorsey Avenue Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/4 ŽÓŌ8 Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Lie PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) Massive **Physician** intra cerepra /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Box 68760, G Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation I Director: A 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 1)206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4946 Easkin Avenue, Baltimore eldman Sadore mD, 21234

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG

08

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 2008 06 /Medical 4c. County of Death Examiner Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1**M**M 2□F Months Hours Feb. 21, 192 Director Baltmore mo Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be a once. 2123 USA Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Wes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City 19a. Informant's Name/Relationship (Type. Print) or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen MD 31234 or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part1. Enter the disease shock, or heart failure. pproximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or a d consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, as t attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Day 5 Other (specify) ed by the a detached for Yes 2 No 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 21 No Other: A Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 056500

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State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Irene Nellie Findley 6:25 P<sup>M</sup> August 5,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Co. Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 245XF Min. 74 216-80-1123 Yrs **Director** July 19,1934 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Evantment with be notified at once. 10c. City, Town or Location Director Maryland Baltimore Dundalk 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3220 Wallford Drive United States 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No 2 If Yes, Give Specify Specify: 3 ☑ Widowed 4 ☐ Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 Years aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Vincenta Chepatis မှ George John Harcarik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9940 Bird River Road (Son) Kenneth Lucas Middle River, MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify) Holly Hill Mem. Gdns. 8/8/2008 Middle River, MD ure of Funeral Service Liquisee 22. Name and Address of Facility Suni Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, mmediate Cause (Final VNO **Physician** new /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or de a consequence o the death certificate be executed as the burial-trar and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknow signed by Hospital or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 6 Other (Specify) WS FUC 1 Yes 2 No filled in by the funeral dir 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manner of D-ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a ca 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within 7 29c. License number 58303 29d, Date signed (Month, Day, Year) 29b. Signature and tale of certifier

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 35e /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner TOWSON If Under 24 Hrs. TOWSON BALTIMORE MANOR CARE -Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Unde Date of Birth (Month, Day, Year) 03/15/1925 Funeral Hours Min Months Days 83 Director 216-20-4064 MD Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shoothe Wedical Examinar in ust be notified at Director 1 X Yes 2 No MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3211 CLARKS LANE, 21215 #106 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Event ODE. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 XNo WHITE Specify ò Specify: 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY BOOK COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OSCAR ဂ FELDMAN SOPHIE KAMEROW 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MURRAY FELDMAN / BROTHER 3714 PARKFIELD ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MENS 08/07/2008 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part / Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Imm // te Cause (Final dise. \* e or condition resulting in death) Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** Presson /Medical Due to (or as a consequence of): Examiner 47 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, physician the death certificate be Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ned by the a detached for ☐Yes 2☐No 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown this certificate has been al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this
filled in by the funeral di 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 D Homicide To the Hospital within 24 hours a To the Funeral D 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar TAMALA S
31. Date filed (Month, Day, Year)

SOBEL, UD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

strar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:30 A<sup>M</sup> August 6, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Ivy Hall Geriatric Center Middle River If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours Months 1 □ M 2XX 1928 Ohio 80 Director 215-24-0280 with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2\times\t Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21221 810 North Essex Avenue permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ 3€Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Assembler 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Alberta Payne 2 James Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 310 North Marlyn Avenue, Essex, Maryland 21221 Susan Marie Golabieski Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 9, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland 2008 Oak Lawn Cemetery 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Servi 70/267 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EMENTA resulting in death) /Medical Due to (or as a consequence of): M-Browceu Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner be executed AMBRIGHT ON burial-trar and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months' 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ H0 24a. Was an , page 2 certificate has performed 1∐ Yes 2 1 N Division or Vital or Attending Physician; director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 ☐ Warsing Home 5 ☐ Residence 6 ☐ Other (Specify) 200 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ို this After this funeral c 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: atural 5 Pending investigation 1 ☐ Yes 2 ☐ No thours after death.

Inneral Director: A
ely filled in by the fu 2 Accident death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide n 24 hou the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 24 and manner stated. 29d. Date signe@ (Month, Day, Year 29c. License number 29b. Signature and title of certifier D Sam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cronw Martici On

Registrar

State

31. Date filed (Month, Day, Year)

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2008

Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 008

			1 - State Registrar		C	ertificate of	Death	F	Reg. No.	10 20000
	TEN	10	Decedent's Name (First, Middle, La.	st)				2. Date of Dea	ath	3. Time of Death
	Physici /Medi		Linda Wel	ls Garcia				August	Day 2008	Year 8 10:58A M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c. County of	
	gere s		848 Harvest Moon	Drive			nton			Arunde1
	Funeral		5. Social Security Number 6. S	I∏M 2DXF	In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	5	55			Aug 14	<b>,</b> 1952	New York
	land ow		10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits
	Mary -f sh ied a	ţò	MD Anne A	runde1		044	enton			1 □Yes 2No
	r 28a	Director	10e. Street and Number	rander		10f. Zip Code		1.	10g. Citizen of Wh	nat Country?
	h with	a D	848 Harvest Moon	Drive			21113		United	States
	deat	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	3. Was Decedent of H If Yes, specify Cub		pecify Yes or No-	14. Race -	- American Indian, White, etc.
9	after or ite	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 💢 No			Specify:	wille, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 ₩ Widowed 4 Divorced	Year or Dates:						White
5	"nat	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade co <i>mpleted)</i>	16a. Dec	cedent's Usual Occup ve kind of work done e. DO NOT use retire	oation during most of work d)	king	16b. Kind of Busi	ness/Industry
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Maryland	d 2 should be filed within th and Mental Hygiene. 7 is marked other than "traumatic event, the Mec	-	19a. Informant's Name/Relationship (	Type. Print)	19b. Ma	ailing Address (Street				tate, Zip Code)
	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. Item 27 is marked other than "natun other traumatic event, the Medical		Nancy Brackley /	Sister	993	Beartown	Road Pai	nted Pos	st, New Y	York 14870
J.e.	of He of He item		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐		20b. Place of Dis	position (Name of rematory or other pla	ce)	Date	20c. Location - C	ity or Town, State
Ĕ	Page nent ant: II		4 □ Donation 5 □ Other (Specif			del Cremat	1	5, 2008	Odento	n, Maryland
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		21. Signature of Funeral Service Dicer	nsee		22. Name and Addre Donaldson	es of Facility			
<u></u>	82 = 89		Could No	Thelio	M01522	1411 Anna	polis Roa	id Odento	on, Mary	land 21113
ft			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused th one cause on each line.	e death. Do not e	enter the mode of dyin	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metas	static '	· rancre	atic A	denocas	TCINOma	Onset and Death  2 Munths
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):	-		-		
н	LAdimine	<u></u>	Sequentially list conditions,	b	oneeguenee of):					
	pe:	ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence or):					
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68760,	ertificate be executed ing physician and e as the burial-transit	Medical		d						
*	The law requires that the death certificate be executed ate has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf					23d. Date	of delivery
. Bo	death ce e attendi	icia	in the past 12 months? 1 ☐ Yes 2 █ No	1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tin		3 □Ectopic pregnanc 5 □ Other <i>(sp</i> ec <i>ify)</i> _	у		Monti	h Day Year
P.0	ires that the de signed by the a be detached to	Physician	9 🗆 Unknown	9□Unknown						
	es tha	by P	Part II. Other significant conditions of	contributing to death but r	not resulting in the	underlying cause giv	ren in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ord	w requir been si should I	ed						1 □ Y	es 2.21No 3	□ Probably 4 □Unknown
ecc	e law r has be je 2 sh	ple						24a. Was a		ere autopsy findings available or to completion of cause of
- H		Completed						perfor	med? dea	ath?  Yes 2 No
/ita	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only or	ne)	
or Vital Records,	hys this al dir	P P	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient			4 Li Nursing Ho		ence 6 □Other	
n	ing Afte une	on:	27. Manner of Death  Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Time Injury	/ Wor		28d. Describe h	ow injury occurred	I
Sic	or Attending after death. Director: After in by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		- At home form	M 1 □	Yes 2 □ No	Off Location (C	tem of a mal file walls and	an Burni Bauta Mumban
Division	I or Attend after death Director: A	Certification:	4 ☐ Homicide determined	building, etc. (	Specify)	street, factory, office		City or Tow	n, State)	or Rural Route Number,
	spital ours neral filled		29a, Certifier 1 SertifyIng Ph	ysician: To the best of r	nv knowledge, de	ath occurred at the ti	me, date and place	and due to the o	cause(s) and mann	ner as stated
	24 h e Fur e Fur letely	Medical	(Check only 2 Medical Exar	niner: On the basis of ex and manner state	kamination and/or	investigation, in my	opinion, death occu	rred at the time, o	date and place, an	d due to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	~	1 1	29c. Licens	se number	2	29d. Date signed	(Month, Day, Year)
	<		Libert Dine	gan Una	ologist	1007	-310181		08/04/0	08
,	0		30. Name and address of person who		h (Item 23a) (Typ	e, Print)	101	3.5	1 1	
_/	U		6369 N. Cha		Bul	TMOTE	11)	21200		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1 . N .				
	Registr	ar	AUG 0 8 2	2008	of State of	13030 261				

Physician

/Medical

Examiner

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

1732 Manor Road

Social Security Number

182-22-0489

Usual Residence of Decedent

Grace

Edna

6 Sex

1 □ M 2 🛣 F

4a. Facility Name (If not institution, give street and number)

10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exal lever - ust be notified at Director 1 ☐ Yes 2 XINo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 1732 Manor Road 21222 S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2X No þ Specify: 3X Widowed 4 □ Divorced 'natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Makin Hagens Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau Dundalk, Maryland 21222 Diane Sufczynski (Daughter) 1732 Manor Road 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Gardens 2008 Middle River, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home PA
1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licensee chau 23a. Part1. Enter the disease, or complications that an the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one eduse or le ch line. Approximate Interval Between Onset and Death Immediate Cause (Final espiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERTENSION 1 Yes 2 No 3 Probably 4 Unknown PERIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an 1 ☐ Yes 2 Wo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled i Medical 29a. Certifier 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  $\theta$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merritt Blud MD ai 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Dundalk

If Under 1 Year

Days

Months

7. Age (In yrs. last birthday,

81

4b. City, Town, or Location of Death

If Under 24 Hrs.

Hours

2. Date of Death

August

8. Date of Birth (Month, Day, Year)

2/5/1927

Day

Year

8:15 PM

Birthplace (State or Foreign Country)

Pennsylvania

2008

4c. County of Death

Baltimore

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25558 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** David Hunger August 4 2008 3:45 PM<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1039 Middlesex Road Essex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 26,1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Min. 1 XM 2 ☐ F Months Hours Yrs Director 218 42 9958 66 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If Item 223a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Evariant in 1916 or cutified at once. Director 1 ☐ Yes 2 ☐ No Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1039 Middlesex Road 21221 A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. ≥ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pressman Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Hunger Edna Mason ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Hunger (Wife) 1039 Middlesex Road Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/5/2008 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue loten Essex, Maryland 21221 23a / vt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): acute disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📜 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 XNo 2 🗆 No Division of Vital 1 □ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1∐Yes 2∭XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No of the state of th 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 2

State Registrar

Medical

29a. Certifier (Check only one)

June

BrunerMD

unes Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1205

29b. Signature and title of certifier

St 32C 32. Registrar's Signature

york Rd

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0040508

Lutherville

29d. Date signed (Month, Day, Year)

08

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:53 AM Hinson August Michael 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner medical cent Mery and University of Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□F Director 28 10-15-1979 ΜD 215-17-2090 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director MD Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or edical Examiner must be 1831 Crofton Parkway, Apt. A 21114 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carolyn M. Newman Eugene A. Hinson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) father/ 1831 Crofton Parkway, Apt. A; Crofton, MD 21114 Mr. Eugene A. Hinson, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or conce. 1 N Burial 2 □ Cremation 3 □ Removal from State 8-07-2008 Maryland Vets. Cem. Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service Licens Services 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Circulatory collapse **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Interior vena Cava compression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Year 3mont Division or Vital Records, P.O. Box 68760 head pencreche anding physician and use as the burial-tran Due to (or as a consequence of) Hodgkins Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown in the past 12 months? Month signed by the and be detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Cardionyogath 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertorme 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 6 Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 2008 of death (Item 23a) (Type, Print) bowy Greene 31. Date filed (Month, Day, Year) AUG 0 8 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Mazie Virginia Hall 2:40 A. 2008 August 07. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore County Timonium Stella Maris If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec • 08, 1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Min. Days Months 1 □ M 2 🛱 F 83 218-14-1507 Baltimore, MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 NO Timonium Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 United States 321 Gail Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceden — Armed Forces? 1 ☐ Yes 2 1 No Black, White, etc 1 ☐Yes 2⅓ If Yes, Give Year or Dates: 1₺ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Secretary n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mazie Reed Jenkins William Benjamin Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland 21093 321 Gail Ridge Road Mr. Ellsworth R. Hall (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel 20c. Location - City or Town, State 20a. Method of Disposition August 08, 2008 1 ☐ Burial 2 Termation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Rie-11 Curcinom. 3717 Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

28a-f show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ire Medical Examiner must be notified at

72 hours after

Pages 1 and 2 s ment of Health ar

Baltimore, Maryland 21215-0036

burial-transi and physician at the burial ası use a ģ the þ signed h Jas page 2 certificate I

requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Physician/Medical 2 Completed Be After this funeral

To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 10 State

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ite Ma 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 032883 Hord J. Man. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Robert Moss, M.D.

31. Date filed (Month, Day, Year) AUG 0 8 2

32. Registrar's Signature

114 Business Center Drive Reisterstown, Maryland

State of Maryland / Department of Health and Mental Hygien 2 0 0 8 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Denise Louise Hittle-Cordial August 2008 2, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1945 Midland Road Dundalk Baltimore Co. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🔀 F 218-78-1791 May 27,1958 Director 50 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene, ant: If Item 27 is merked other than "naturel", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location other traumetic event, the Medical Examiner must be notified at Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 7564 Westfield Road 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Corp. 12 Years Assembly Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Szymanski Melvin Hittle ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 7564 Westfield Road Mr. Thomas G. Cordial (Husband) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important: If it any Injury or o Number 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 8/6/2008 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a . T1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

**Physician** /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans

Box 68760-

P.O.

of Vital Records.

Division

Examiner

Physician/Medical

by

Completed

Be

Medical Certification: To

IF FEMALE:

Immediate Cause (Final

disease or condition resulting in death)	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	

Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

We Lastatic

Due to (or as a consequence of):

Due to (or as a consequence of)

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Day Month

1 ☐ Yes 2 12 No 9 Ulnknown

23b. Was decedent pregnant

in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

4 Pregnant at time of death

24a. Was an autopsy perform 1 ☐ Yes 2 11No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No Sister's

3. Time of Death

7:15 A

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Maryland

White

21222

Approximate Interval Between Onset and Death

monte

Year

21222

Year

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pending investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 6 □Could not be

and manner stated.

Other: 4 Nursing Home 5 Residence 6X Other (Specify) 28b. Time of Injury 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check o

2 Accident

4 Homicide

3 ☐ Suicide

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

29b. Signature

determined

Mas.

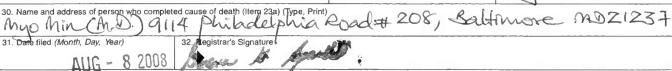
Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 045390

29d. Date signed (Month, Day, Year) August 4 2008

State Registrar

31. Date filed (Month, Day, Year) Registrar's Signature



### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 25562 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 8 Day Year **Physician** 10:00 PM ELIZA MENSON 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Levindale Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 □ F Director 101 25 1907 WV 215-14-7962 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Per 27 Is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notifled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21207 3711 Ferndale Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucy Carr Armstead Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ferndale Ave, Baltimore, Md 21207 Department of Health Important: If item 27 any Injury or other the once. Howard Henson Jr.-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 8/16/2008 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 Rome Baltimore, Thompson 4300 Wabash Ave, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COMPLICATIONS STROKE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA STAGE 2 No 3 Probably 4 → hknown 1 ☐ Yes Be Completed RENAL CHRONIC FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy certificate 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

within 24 hours aft

To the Funeral Di

completely filled in

<sub>o</sub>State Registrar

BABATUNDE 31. Date filed (Month, Day, Year)

AUG 0 8

2008

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. AJANI 32. Registrar's Signature

ATTENSING

and manner stated.

BALTIMONE

PHYSICIAN

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064533

BELVEDERLE

·MD 21215

29d. Date signed (Month, Day, Year)

(LEVINDALE GERLATTIC CTR)

ANENUE

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Month SOP Jessie M. Holt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Village Luture ( Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. 1 M 2XX 186-28-7079 Director Feb. 22, 1933 SC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Martical Examiner must be rudified at once. Baltimore MD Director 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 2327 N. Charles Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc Specify: Black 1 Tes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo þ Specify: 3 X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Schools cafeteria aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Mayo Thomas Mayo 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5212 Hillwell Road; Baltimore, Maryland 21229 James Holt, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/05/2008 Catonsville, Maryland Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Was an autopsy performed?
Yes 2 No 2 NO 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after use To the Funeral Director: Af 1 ☐Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J-Eutan St. Baltimo 31. Date filed (Month, Day, Year) AUG 0 8 2008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Arlington L. Howe 26 2008 **July** 1:10 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Nursing Home and Hospice Ctr. Towson If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□ F Months Days Hours 220-26-6485 Director Sept. 15, 1925 MD Usual Residence of Decedent 10h County 10d. Inside City Limits 10a State 10c. City. Town or Location 28a-f shov ttem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, I'm Wedical Evaniant must be notified at MD Baltimore 1 🖫¥es 2 🗆 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 1190 W. Northern Parkway 21210 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black ð If Yes, Give Year or Dates: 1 □Yes 2 XXNo Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Imalian security guard Stanley Smith Security Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Howe Ursula Johnson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Mildred Harriday / Guardian 1190 W. Northern Parkway; Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Garrison Forest Vet. Cam. 07/30/2008 Owings Mills, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oaset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician lays /Medical Due to (or as a consequence of): Examiner EMENTIA ND STAGE Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably W Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has t page 2 s autopsy perform certificate 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' examiner: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State Registrar Kendall

31. Date filed (Month, Day,

Year

055W.

32 Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

owschizen

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:05 PM LAWRENCE STEVEN HARRIS 2008 4ugust /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 600d N/A If Under Date of Birth (Month, Day, Year) 04/22/1957 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1X M 2□ F Months Hours 215-48-1343 51 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show injury or other traumatic event, the Medicel Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or Items 23a 12602 SAGAMORE FOREST LANE 21136 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) MECHANICAL permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED SERVICE REPAIR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PAUL HARRIS JOAN ဥ HARRIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY HARRIS / WIFE 12602 SAGAMORE FOREST LANE, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FORBAND CEMETERY 08/07/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** on disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of autopsy performed death?
1 ☐ Yes 2 🗀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifies 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number (wo, mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) Raven Boulevard MD, 560 32. Registrar's Signature 31. Date filed (Month, Day, Yea State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of Mar State of Mar Registrar	-	artment of H rtificate of L	leaith and Me D <i>eath</i>	ental Hygle Reg.	ne No. 2008	25566			
	Physicia	an	1. Decedent's Name (First, Middle, Last) Stanley John Janaites				2. Date of Death Month AUGUST	Day Year 05. 2008	3. Time of Death			
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	Cumbus	4b. City, Town, or	Location of Death		4c. County of Death				
Í	Funeral Director		Saint Joseph Medical 5. Social Security Number $\begin{array}{ccc} 6. \text{ Sex} & 7. \text{ Age} \\ 1 & \text{7} & \text{M} & 2 & \text{D} & 79 \\ \end{array}$	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Ye		place (State or Foreign ntry)			
	and w		Usual Residence of Decedent  10a. State 10b. County 1	10c. City, Town or Lo	cation				10d. Inside City Limits			
	a-f sho	ctor	MD Howard	Cooksvil	le				1 □Yes 2 No			
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 978 Hoods Mill Road		10f. Zip Code 21723			. Citizen of What Cou SA	ntry?			
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Madical Evanter rust be nutified at	þ	11. Marital Status  1	er in U.S. 13. \	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 【XNo	ispanic Origin? (Spec in, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White, wh Specify:				
21215-0036	n 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of working l)	161	b. Kind of Business/Ir	ndustry			
212	filed within Hygiene. vther than "	Com	Elementary/Secondary (0-12) College (1-4or 5+)	)	Catholic	priest		Clergy				
and	id be filk lental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last) Stanley J. Janaites			18. Mother's Name ( Teresa Gr		den Surname)				
, Maryland	and 2 should saith and Men 27 is marke er traumatic		19a. Informant's Name/Relationship (Type. Print) Mr. George Wachter (Friend)	1102	1 Haughs	and Number or Rural Church Roa						
Baltimore,	permit. Pages 1 and 2.8 Department of Health a Important: If item 27 is any Injury or other trau once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		dge Memor	ial 8-8-0	08 E11	c. Location - City or T kridge, MD				
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licensee  Buan L. Height			<sup>ss of Facility</sup> Haig 95 Sykesvi			_			
2			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ne death. Do not ent	ter the mode of dyin	ig, such as cardiac or	respiratory arrest	,	Approximate Interval Between Onset and Death			
	Physician /Medical		disease or condition resulting in death)  a. HellEREME  Due to (or as a consequence of):									
	Examiner	in lie	Sequentially list conditions, if any leading to immediate	FAILURE consequence of):					2 WEEKS			
N	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	series quaries siji								
68760,	icate be executed physician and ; the burial-transit	al Ex	resulting in death) Last Due to (or as a	consequence of):								
189	rtificate ing phy as the	Medical	IF FEMALE:									
.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	☐ Fetal death 3 ☐	☐ Ectopic pregnanc ☐ Other (specify)	у		23d. Date of deli Month	very Day Year			
ords, P.	w requires that the di been signed by the should be detached	by	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death? obably 4 ☐ Unknown			
of Vital Records,	: The law re icate has be ; page 2 sho	Completed					24a. Was an autopsy performer 1 □Yes 2	prior to c d? death?	opsy findings available ompletion of cause of			
Vita	ysician: The s certificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Mulnoatien!	t 2 ☐ ER/Outpatier	nt 3 □ DOA Oth	26. Place of Death er: 4 ☐ Nursing Hom		ce 6 Other (Spec	ifv)			
	iding Physician: th. After this certifications funeral director,	ion: T	27. Manner of Death  ↑ Natural 5 □ Pending (Month, Day,	Year) 28b. Time of Injury	Worl	y at 28	3d. Describe how					
Division	or Atten after deal Director: I in by the	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, str ( <i>Specify</i> )		Yes 2 □ No 26	3f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,			
	To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	examination and/or in								
	To the within To the Comp	Me	29b. Signature and title of certifie	MD	29c. Licens		29d	I. Date signed (Month	Day, Year)			
	3		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,		% / W		0/0/	<i>O O</i>			
	Sta	ite	31. Date filed (Month, Day, Year) 32 Registrar	's Signature	Tier leaf Issue beste 1	RIVE TOW	SON, MC	RYLAND 8	21204			
	Registr		AUG 0 8 2008 Letter	Mr From	all of							

8-059		Latera	Please Type or Print in Black Indefible Ink. Ensure All Copie  son State of Maryland / Department of Health and Mental H	es Are Legible.							
osepr	Thomas		I- For State of Maryland / Department of Health and Mental H	Reg. No. 2008 2556							
1	Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Death							
М^ "-	al Exami		Joseph Thomas Johnson	Month Day Year 1945 hrs							
1			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	th 4c. County of Death Baltimore County							
<i>[</i>			5904 Prince George Street Woodlawn  5 Social Security Number 16, Sex 17, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs								
	Funeral Director		210_66_1777	- Country)							
S.	Birector		1 M 2 F 55 Yrs.	772271333 NO							
	any		10a. State 10b. County 10c. City, Town or Location	10d. tnside City Limits							
	≥l	5	MD Baltimore Baltimore	1 X Yes 2 No							
	Maryli 28a-f d at o	Director	10e. Street and Number  10f. Zip Code	10g. Citizen of What Country?							
	th the 23a or notific		5904 Prince George St. 21207  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	USA  Specify Yes or No-  14. Race - American Indian, Black,							
	ath wi	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	to Rican, etc.) White, etc.							
	her de ", or i er mu		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Specify: White							
	ours al atural xamin	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use rel	f work done 16b. Kind of Business/Industry etired)							
ي	n 72 h Ian "n ical E	) jet	Elementary/Secondary (0-12) College (1-4 or 5+)  Iron / Steelworker								
- 6	withii giene. her th	Completed		ne (First, Middle, Maiden Surname)							
21215-0036	e filed tal Hy ked of	Be C	Thomas Johnson J	osephine							
2	ould b d Men s mar iic eve	မ		or Rural Route Number, City or Town, State, Zip Code) e St. Balto, MD 21207							
2	nd 2 sh alth an m 27 i	L	Annette Johnson spouse 5904 Prince Georg	Date 20c. Location - City or Town, State							
2	of He		1 Burial 2 V Cremation 3 Removal from State crematory or other place)	- <b>5-08</b> <del>\$5/08</del> Glen Burnie, MD							
Baltimore	Default Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Ì	4 Donation 5 Other Specify: Atlantic Crematroy 8  1 Signature of Fundal Service Licensee 22. Name and Address of Facility S 1	193700							
ă	Depa Depa Impo	V	MVIII W 1 1 12 M 1 1 1 2 M 1 1 M 1 1 M 2 1 2 1	Dia Pike, MU ZIU43							
	hysician		23a. Part I. Enter the tilsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	c or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death							
	Medical xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Contact Gunshot Wound to Neck  Due to (or as a consequence of):	Desti							
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
-,	=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
V	LOCICES, P.O. BOX 60/60,  Iaw requires that the death certificate be executed thas been signed by the attending physician and 2 should be detached for use as the burial - transit	ical E	UNPENDED 3,20b per fh g882 8-8-08 vt								
ç	te be e nysicia	Nedi	IF FEMALE: 23c. If yes, outcome of pregnancy	23d, Date of delivery							
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	eath ce eath ce attend for use	sici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)								
2	it the d by the tached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
	res that signed the de	d by		1 Yes 2 ✓ No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available							
-	v requires been should	Completed		24a. Was an autopsy findings available prior to completion of cause of death?							
	Kecc The lay icate ha	l wo		1 ✓ Yes 2 No 1 ✓ Yes 2 No							
7	ral F rian: ' rertifi ector, j	Be O	25. Was case referred to medical examiner? Hospital: 1 Ingalient 2 FR/Outpatient 3 DOA Other; 4 Nurs	eck only one) rsing Home 5 Residence 6 ✔ Other: Scene							
	I OT VITAL KER ing Physician: The After this certificate funeral director, page	ို	1 V yes 2 No 28b Time of Injury 28c Injury at Work?	28d. Describe how injury occurred							
	on on on on on on on on the function of the function of the function of the one of the other of the one of the one of the other of the oth	ion	1 Natural 5 Pending FOUND: FOUND: 1 Yes 2 No	Subject shot self							
:	IVISION or Attend after death. Director: in by the f	ficat	2 Accident Investigation Aug 1, 2008 1936 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
i	DIVIS Hospital or A 24 hours after Funeral Dire	Certification:	4 Homicide determined (Specify) Single Family	5904 Prince George Street, Woodlawn, MD							
	UIVISION Of VITAI RECORDS, P.O. BOX 66/60, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	la l	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)							
	To th withi To th	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)							
		-	O.C.M.E.	August 2, 2008							
	\		30. Name and address of person who completed cause of death (Item 23a)								
	1		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD	21201							
	, Regi	State	31. Date filed (Month, Day, Year) AUG 08 2008 32 (Registrar's Signature								
	Kegi	ગાલ	1144								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 25568 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1835PM Autumn Johnson /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manjard 6. sex TIMOYE Med icala If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖵 F Yrs **Director** N/A7-15-2008 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the micigal Examinations to multilise at Director 1 ☐Yes 2 ☐ No MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4013 Edmondson 21229 USA Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1√ Never Married 2 Married 1 ☐ Yes 2√ No þ Specify: Specify 3 Widowed 4 □ Divorced Black Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working N/A life. DO NOT use retired) N/A Elementary/Secondary (0-12) Mental Hygiene. arked other than College (1-4or 5+) N/AN/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental is marked o Trevon Johnson Nicole Gamble ဥ aryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. Nicole Gamble-Mother 4013 Edmondson Avenue Balto, MD 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State **X**Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-11-2008 11-2008 Balto March East F/H Lorraine Park 21. Signature of Funeral Service Liouns 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due o (or as a consequence of): disease or condition resulting in death) /Medical Examiner sendomona Sequentially list conditions, if any, leading to influed at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan; The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760% Due to (or as a consequence of) Physician/Medical as IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 autopsy performed? yes 2 No certificate 1 ☐ Yes 2 🗆 No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 Tes 1 npatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number NINAMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Balto. 22 ternando 31. Date filed (Month, Day, Year) 32. Registrar's Signature State fresh s

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Ma Registrar Amend Item 26 per ver	ryland / Dep <b>b. ,g882<sub>c</sub>0</b>	artment of F 8/08/08 dh	lealth and N Beath	lental Hy	giene 20	08 25569	
Physici		Decedent's Name (First, Middle, Last)  WILLIAM	540	OB	54	2. Date of De Month AUC.	Day	Year O 1 12 Am	
/Medic Examin		4a. Facility Name (If not institution, give street and number)	• / /	4b. City, Town, o	r Location of Death	13-10.	4c. County of		
2		Good Samaritan Hos	DItal	15a/1	IMOre			more City	
Funeral Director		4M 40	(In yrs. last birthday 61 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan. 1	1,1947	Birthplace (State or Foreign Country)     Maryland	
pur M		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits	
Maryla f sho	lor	Maryland Baltimore City	-	timore Ci	ty			1XXYes 2 No	
r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country?	
th with	ralD	4807 Arabía Avenue		2	1214		USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, I'm Marical Examiliar mast be neithed at once.	by Funeral	11. Marital Status  1 □ Never Married 2 Married  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  X MYes 2 □ No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 💆 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, s, White, etc. White	
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ild be fi fental h rked ot tic ever	To Be	Roland Jacob				a Haddi		"	
nd 2 shou alth and M 27 is ma		19a. Informant's Name/Relationship (Type. Print) Gloria L. Jacob (Wife)		ing Address (Street Arabia A					
es 1 a of Hear litem		20a. Method of Disposition	20b. Place of Disp	osition (Name of ematory or other place	ce)	Date	20c. Location - 0	City or Town, State	
Page tment tant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Gardens		8-6-	2008	Baltimo	re, Md.	
permit Depart Import any Inj		21. Signature of Funeral Service License	ľ	Lassann F 7401 Bela			. Md. 21	236	
		23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not er	nter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	snow wo	L CONCE	r in	W-	Onset and Death	
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leath certific attending p	Physician/Me	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?  1 □ Vo. 2 □ Nhs  4 □ Pregnant at	Fetal death 3	☐ Ectopic pregnand	y		23d. Date Mon	e of delivery th Day Year	
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hysic this ce	To E		t 2 XER/Outpatie	ent 3 DOA Oth	er: 4  Nursing Ho	ome 5	dence 6 Othe	r (Specify)	
ding Physician; The Information After this certificate his funeral director, page		27. Manner of Death 28a. Date of Injury (Month, Day,	Year) 28b. Time Injury	Wor	k?	28d. Describe	how injury occurre	d	
Attendation of the	ficat	2 Accident investigation  3 Suicide 6 Could not be determined 28e. Place of Injur	y - At home, farm, s		Yes 2 □No	28f. Location (	Street and Numbe	r or Rural Route Number,	
s after s all Dire	Certification:	4 ☐ Homicide determined building, etc.	(Specify)			City or To		,	
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Whin 24 hours after death.  The the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of Medical Examiner: On the basis of and manner state.	examination and/or i	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as stated. nd due to the cause(s)	
T WOO	Me	29b. Signature and title of certifier		29c. Licens	_		-	(Month, Day, Year)	
1/		Jumy mum		D121	35		AUG 41	2004	
(2)		30. Name and address of person who completed cause of de	57011 W	NA VOVE	v suro	snow	ms, mg	21239	
Sta * Registr		31. Date filed (Month, Day, Year) 32. Registral	's Signature	le					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:05 AM Hugust bhnson ndela 2008 /Medical (If not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death **Examiner** ti more Hospice Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Hours Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any lujury or other traumatic event, the Medical Example must be notified at once. 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Funeral Director more 10e. Street and Na 10f. Zip Code 10g. Citizen of What Country? 21217 tvenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hss istant 17. Father's Name (First, Middle, Last) Be lames ဂ္ 19a. Informant's Name/Relationship (Type. Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 20b. Place of Disposition (Name of temetary, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State Baltimore, 21. Signature Funeral Service Licensee Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastati Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to finite diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dus to (or as a consequence of) burial-tran Due to (or as a consequence of) the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 5 Other (specify) 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2 🗷 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Author (Specify) NESS Pice 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of pertifier 29c. License number 056211 CM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Banover St. Baltimore MD 21225 MD 300( 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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	Physician
	/Medical
	Examiner
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**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

For State Registrar			ertificate o	or Doutin			Reg. No	J					
1. Decedent's Name (First, Middle, Las	st)					2. Date of D	Death Da	av Y	ear	3. Time o	of Death		
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5. Social Security Number 6. S		e (In yrs. last birthd		) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day.					9. Birthplace (State or F Country)				
408-94-6937	1 <b>X</b> M 2□F	55 Yrs	Months Da	ays Hours	1	$\frac{Month, 1}{Mov}$	195	2	Count	19)	unk		
Usual Residence of Decedent													
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MD		Balt:	imore							X Yes	2 □ No		
10e. Street and Number			10f. Zip Cod	 de			10g. C	itizen of Wha	at Count	try?			
115 E. Melrose	Avenue			21212				US	Α	•			
	12. Was Decedent	Ever in II.S. I 1	13 Was Decedent	of Hispanic Or	igin? (Sne	cify Ves or I	lo-	14. Race -		an Indian			
11. Marital Status  1 Never Married 2 Married	Armed Forces?		<ol> <li>Was Decedent If Yes, specify</li> </ol>	Cuban, Mexica	n, Puerto I	Rican, etc.)	10		White, e				
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17. Father's Name (First, Middle, Last,	,		um	10. MOUN	ei s inaille	(Filst, Midd	ie, ivialue	n Surname)			unk		
19a. Informant's Name/Relationship (		I	lailing Address (St.				_						
Genesis Long Gre	en	1	15 E. Me.	rose A	venue	Balt	imor	e, MD	212	212			
20a. Method of Disposition		remeter/	isposition (Name o		D	ate	20c. l	ocation - Cit	ty or To	wn, State			
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State Registrar 31. Date filed (Month, Day, Year)

AUG 0 8 2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	,	1 - State of Maryla		artment of H			giene Reg. No. 20	08	25	572
Physicia	an	Decedent's Name (First, Middle, Last)     Tony Maurice Jones				2. Date of Dea Month	ath Day	Year	3. Time o	
/Medic Examin		4a. Facility Name (If not institution, give street and number) 2524 Marbourne Avenue		4b. City, Town, or	Location of Deat	<u>  08</u>	04 200 4c. County		5:30	Р
Funeral Director			s. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		9. Birthpla Country	ice (State y) MD	or Foreign
g		Usual Residence of Decedent  10a. State 10b. County 10c. (	Dity, Town or Lo	cation		1106. 219	1,737	100		City Limits
the Mar 28a-f sl	Director	MD 10e. Street and Number		Baltimor	e 		10g. Citizen of W	/hat Countr		s 2□No
ath with		2524 Marbourne Avenue			21230			USA		
aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Evandrer must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Mas Decedent Ever in Armed Forces?  1 □ Yes 2 □ Nover Married 2 □ Nover Marri		Was Dec <i>e</i> dent of Hi If Yes, specify Cuba 1 □ Yes 2 ₩No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black	e - Americar k, White, etc : Blac	c.	
215-0036 tthin 72 hours aft nen "netural", or	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired		16b. Kind of Bu				
ified worth Hygier other the	Be Cor	1.2   17. Father's Name (First, Middle, Last)		custodian	18. Mother's Nar	ne (First, Middle,	Social Sec Maiden Surname		<u>Admin</u>	<u>istrati</u> c
arylano	To B	Cornelius Veney	T			orrine Jon				
IOCe, Maryla ges 1 and 2 should tt of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print) Hilda Jones / Wife		ng Address (Street a Marbourne				State, Zip C 21230	(ode)	
More Pages 1 annunt of He Intt: If item Iry or othe		I Dounal 2 Decremation 3 D Removal from State	Place of Dispo cemetery, crema	sition (Name of matory or other place		Date 9/2008	20c. Location	•		
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked other any Injury or other traumatic event once.		4 □ Donation 5 □ Other (Specify) Met  21. Signature of Funeral Service Licensee	22	2. Name and Addres	s of Facility Wy	lie Funera	,	.A.	_	
∼ Physician		23a. Part 1. Enter the disease, or complication that caused the de shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition		er the mode of dyin				A Ir	Approxima nterval Be Onset and	etween I Death
/Medical Examiner		resulting in death)  a.  Due to (or as a const			1000	Juner	toncin	1	ear	~
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atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	tal death 3	Ectopic pregnancy Other (specify)	'		23d. Date Mor	e of delivery nth D	y Day	Year
S, F es that igned b	þ	Part II. Other significant conditions contributing to death but not rely lymphedema if the low	esulting in the ur	nderlying cause give	n in Part I. Hes		lid tobacco use contribute to the cause of dea □ Yes 2 121√10 3 □ Probably 4 □ Uni			
e lar	Completed					24a. Was a autop perfor	sy p med? d	Vere autops rior to comp leath?	pletion of	available cause of
OT VITAL F Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?		Othe	.41	ath (Check only or	ne)			
L fe g	tion: To	1 Yes 2 No Tiospital 1 Inpatient 2  27. Manper of Death 1 Natural 5 Pending 2 Accident investigation 2  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	4 □ Nursing F	lome 5 ☑ Resid	ence 6 Othe			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	eet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rural F	Route Nui	mber,
re Hospit 124 hour re Funera	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated	ted. he cause	(s)
To th within To th	Me	29b. Signature and title of certifier  Muly Fairchild M	D	29c. License D 3	number	:	29d. Date signed	(Month, Da	Month, Day, Year)	
b		30. Name and address of person who completed cause of death (Ite	em 23a) (Type,	Print)	d St. s	inte 12	o Bal	time	ove	MD
Sta Registra	te ar	30. Name and address of person who completed cause of death (It Emily S. Falvchild MD 4/ 31. Date filed (Month, Day, Year)  ALIG 0 8 2008  Registrar's Sig	parture 100	de			)			

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			1 - For State Registrar	State of Marylar	•	artment of F rtificate of I		•	giene Reg. No. 2	08 25573
			Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	Physicia		William R. Keyser	Jr.				Month AUGL	JST 4, 6	Year 2008 10:30FM
	/Medic Examin		4a. Facility Name (If not institution, give stre	eet and number)	nter	4b. City, Town, or	r Location of Death Tows	on	4c. County	of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 14 Number 14 Number 14 Number 15	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 11–30–	av. Year)	9. Birthplace (State or Foreign Country) Md.
	ъ		Usual Residence of Decedent							
	arylan show	_	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits 1 □ Yes 2 ☒ No
	Ba-f:	Director	Md. Balto	•	Cock	eysville				
	with the	à	10e. Street and Number 300 International	Cirolo		10f. Zip Code 21030	1		10g. Citizen of W	
	eath '	eral	T	Was Decedent Ever in U	IS 13			pecify Yes or No		e - American Indian,
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the alth and Mental Hygiene. Other T is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marical Eventing to use the notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced	Armed Forces?  LYes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black Specify:	k, White, etc.
	2 hou	ted	15. Decedent's Educat	ion		dent's Usual Occup	pation during most of work	ring	16b. Kind of Bus	siness/Industry
71717	d within 7 giene. er than "r	Completed	(Specify only highest grade c	College (1-4or 5+)	life.	ditor	d)		B+0/C+0	Railroad
2	be file tal Hy doth event	a	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Surname	9)
7	ould Men narke	၉	William R. Keyser,S						. Griffi	
-	12 sh thanc 7 is n traun		19a. Informant's Name/Relationship (Type.	•		,	and Number or Rui			
. ע	1 and Health em 27 other tr		Linda C. Hoppe  20a. Method of Disposition	Niece 20b.	Place of Dispo	sition (Name of		Jarrett Date		Md. 21084 City or Town, State
2	permit. Pages 1 and 2 g Department of Health a Important: If item 27 is any Injury or other trau once.		X Burial 2 ☐ Cremation 3 ☐ Ren		cemetery, cre	matory or other plac	ith 8-7-		Balto.	ony or rown, class
	nit. P artme ortan Injur E.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee			2. Name and Addre	on of English			7 77
ă	permit. Departr Importa any Inju		Vikecco ((	(-(		9705 F			ek Funer	ат ноте Md. 21236
ı			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the dea	th. Do not en					Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	SEFSIS						Onset and Death
No.	/Medical		resulting in death)	Due to (or as a conse	quence of):					I have I o'have have I a have
	Examiner	<u>.</u> .	Sequentially list conditions, b							
1	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					
V	s be executed sician and burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):					
50,	le be /sicia: e buri		d.							
8	Tifical ng phy as th	ledi	257							
. DO	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the tompletely filled in by the funeral director, page 2 should be detached for use as the tompletely filled in by the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □Yes 2 □No 9 □ Unknown	If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	☐ Ectopic pregnanc	<b>Э</b>		23d. Date Mor	e of delivery nth Day Year
	s that ned b s deta	by Pt	Part II. Other significant conditions contri	outing to death but not re	sulting in the u	ınderlying cause giv	en in Part I.	23e. Did	tobacco use contr	ibute to the cause of death?
ğ .	quire: en sig uld be	q pa	ADVANCED CHRONIC	COBSTRUCT	IVE	PULMON	ARY	10	Yes 2 No	3 Probably 4 Unknown
2	aw re as bed 2 sho	Completed	DISEASE					24a. Was	an 24b. V	Vere autopsy findings available
	Ine I	ĕ						auto perfo 1 □Yes	ormed/?	leath?
	clan: ertific ctor,	Be (	25. Was case referred to medical examiner?				26. Place of Dear			
5	hysio this o	၉	1 Yes 2 Hos		ER/Outpatie		4 LI Nursing no		idence 6 ☐ Othe	
	ding Physician: The h. h. After this certificate h. funeral director, page	ion	27. Manner of Death  1 → Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	k?	28d. Describe	how injury occurre	ed
	or Attendate death Director:	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm st		]Yes 2□No	28f Location /	Street and Number	er or Rural Route Number,
֝֟֝֓֓֓֓֓֝֟֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	ital or A	Certification:	4 ☐ Homicide determined	building, etc. (Spec	ity)			City or To	wn, State)	
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 156 Certifying Physic (Check only one) 2 Medical Examine	ian: To the best of my knr: On the basis of examinand manner stated.	owledge, dea ation and/or i	th occurred at the ti	ime, date and place opinion, death occu	, and due to the rred at the time	e cause(s) and ma , date and place, a	anner as stated.  and due to the cause(s)
i	With Solar	Σ	29b. Signature and title of certifier	n		29c. Licens			29d. Date signed	(Month, Day, Year)
	00		· Cestall	D, My			1886		dua	ust 4, 2008
	'JU		30. Name and address of person who com	/					_ ()	, ,
	Sta	te	31. Date filed (Month, Day, Year)	M. D. 76 (2) 1 ( 32. Registrar's Sign		DRIVE T	UWSON,	MARYLA	ND 2126	74

State Registrar

AUG 0 8 2008

Registrar

(Check only one)

29b. Signature and title of certifier

Sebastion 207-31. Date filed (Month, Day, Year) AUG 0 8



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

M.D

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

00055171

Parenne Baltimore

29d. Date signed (Month, Day, Year)

08108108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05928 State of Maryland / Department of Health and Mental Hygiene Nicholas M. Kordell 2008 25575 1- For State Certificate of Death Reg. No Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ August 2, 2008 2055 hrs Medical Examiner Nicholas Michael Kordell 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Baltimore Months Davs Hours 1 X M 2 F CountryMaryland Director 213-31-3412 17 Sept.11,1990 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 X No Maryland|Baltimore County Essex 23a or 28a-f show Directo 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 606 Riverside Road 21221 United States the 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the <u>Medical Examiner must be a</u> Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 XNever Married 2 2X No Yes White Yes 2 X No specify. If Yes. Give Year Specify Pages 1 and 2 should be filed within 72 hours after Widowed 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12 N/A Carpenter's Helper Carpentry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Charles Kordell Alvera Michelle Masilek 19a. Informant's Name/Relationship (Type, Print ) (Aunt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Riverside Road Mrs. Elizabeth A. Schenning Essex, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State August 07, permit. Page: Department o Evergreen Mem. Park Finksburg, Maryland 2008 Donation 5 Other Specify 2. Name and Address of Facility
eaceful Alternatives Funeral&Cremation Ctr.,P.A
2325 York Road Timonium,Maryland 21093 21. Signature of Funeral Service Lic. an Timonium, Maryland ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval disease, of Physician Between Onset and ailuge. List by one cause on each Medical Death a. Head Injuries Immedi te Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury triat initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be of Vital Other; examiner? Hospital: 1 🗸 Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 this ٩ 1 ✔ Yes No 28a. Date of Injury Авег 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Operator of a motor scooter involved in a Jul 29, 2008 2318 hrs Natural Division Yes 2 V No death. Pending collision with an automobile 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State)
Philadelphia Rd & Campbell Blvd, White Marsh, MD determined (Specify) Local Street Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. August 3, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL OCME

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** W. Kafer, Sr. 2:15A M Charles 5, 2008 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Hospital Bel Air Harford Co. 8. Date of Birth (Month, Day, Year)
Feb. 18,1911 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 □ F 97 Yrs. Maryland 212-10-2030 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Co. Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a or 21224 United States 420 Overview Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married o. Maryland 21215-0036 1 ☐ Yes 2 No Specify White ģ 3₺Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than "I College (1-4or 5+) Years Elementary/Secondary (0-12) Smelting Copper Co. Master Mechanic 12 should be filed w h and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia Appel William Kafer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19c. Maryland
21206 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Mrs. Judith McDermott (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 8/8/2008 Baltimore, Maryland 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the 4 eas shock, or hea Approximate Interval Between Onset and Death omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. 2 days **Physician** Depsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner unerl Kneumoma Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or and consequence of): rechs Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed Vital 1□ Yes 2☑No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ Division or funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide or A thin 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DS 3186 MD August 5,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lo 615 W. McPhail Rd Bel MD Air mo 21014 Tinney 22. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG - 8 2008 Registrar

800.48.092

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician nthonis 2008 8:11 Augus-≤/Medical 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDAllstown 2002 Consterios HOSPI Baltiman If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral XX**<sup>M</sup> 2□ F Min. Davs Hours 58 Director 215-52-4440 8-9-1949 MDUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1√ Yes 2 No Director N/A Balto MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6814 Townbrook Drive Apt B 21207 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2∏No XX Specify. þ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) llth grade N/ADisabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f nent of Health and Mental I int: if item 27 is marked ol Mary Williams Edward Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corita Gervais-Sister 7161 Fairbrook Road Balto, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ortant: if it injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or once, King Memorial Pk 8-11-2008 Randallstown, MD 21. Signature of Funeral Service Legis 22. Name and Address of Facility March F/H East E. 1101 Avenue Balto, North 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atherosclerat Cardiciasculais disease or condition resulting in death) /Medical Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (br as a consequence of): Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe 2 X No I or Attending Physician; after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HCC55644 30. Name and Aldress of person who completed cause of death (Item 23a) (Type, Print) 5461 OH Coast 21133 Rd Randallstown

Registrar

State

31. Date filed (Month, Day, Year)

2008 Brown B. Spell

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of O

			1 - For State Registrar	State of M	iai yiai ic		tificate of	Death		Reg. No.	08	255 / 8
	Physici /Medi		1. Decedent's Name (First, Midd Carolyn T. Lay						2. Date of De Month <b>Augus</b>	Day	OO8	3. Time of Death 7:00 PM M
	Examir		4a. Facility Name (If not institution Suburban Hosp		)		4b. City, Town, o	r Location of Death		4c. County	of Death	cy
	Funeral Director		5. Social Security Number <b>221–18–8919</b>	6. Sex 1 □ M 2 M F	ge (In yrs. la 78	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 07 / 26	th ly, Year) 1930	9. Birth Cou <b>DE</b>	place (State or Foreign htry)
	yland now		Usual Residence of Decedent  10a. State  10b. County	/	10c. City,	Town or Loc	ation				1	0d. Inside City Limits
	a-fsh	ctor	MD Mont	tgomery	Kei	nsingt	on					1 □Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of		
	s 23a	ra	3618 Littleda				20895			Unite		
0036	filed within 72 hours after death with the Maryland Hygiene. Hyer than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Ma  3 □ Widowed 4 ☒ Divorced	If Ves Give	?	1	□Yes 2⊠No		ecity Yes or No Rican, etc.)	Specia	ck, White,	te
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any Injury or other traumatic event, Ital Medical once.	mplete	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4or	5+)	16a. Deced (Give I life. D		oation during most of work d)	ding	16b. Kind of B Banki		dustry Finance
land 2	ld be filed ' lental Hygi ked other ic event, II	To Be Co	17. Father's Name (First, Middle Yngvar Tjers					18. Mother's Nam	e (First, Middle,		ne)	
Mary	nd 2 shou alth and M 27 Is mar r traumat	-	19a. Informant's Name/Relation Andrew Caffey/					and Number or Ru				,
more,	Pages 1 and of Heiler of Heiler of Heiler of Heiler of Heiler or other or o		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 4 ☐ Donation 5 ☐ Other (3		<b>:</b> [		ition (Name of atory or other place ake Crema		Aug 6 2008	20c. Location Beltsv		own, State Maryland
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service	· · · · · · · · · · · · · · · · · · ·	0382	22.		ss of Facility ral & Cren	nation Se ver Sprin	ervices ng, Mary	land 2	20910-
4	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that cause to only one cause on each I a.  SEPTION  Due to (or as b.	ine. SI s a conseque	HOCK ence of): SION	r the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
The	rtificate be executed og physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any course of the following cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	3EPS	ence of):						
184	tificate be ng physici as the bu	edical		d. ARF	(AC	UTE	RENAL	FAILUE	RE)			
/υ ς .O. Box	law requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify) _	у			ate of deliv	ery Day Year
8/4 ds, P	uires that signed b	d by Pl	Part II. Other significant condit	ions contributing to death t	but not resul	ting in the un	derlying cause giv	en in Part I.		obacco use con Yes 2 □ No	tribute to t	he cause of death?
ROLYN of Vital Record	The ate h	Completed by							24a. Was autor perfo 1  ☐ Yes	an 24b. osy rmed?/ 2 DaNo	Were autoprior to codeath?	opsy findings available impletion of cause of
Vita	Physician: The ribis certificate ral director, pag	Be (	25. Was case referred to medical examiner?		1		lau.	26. Place of Dear	th (Check only o	ne)		
	alng Phys n. After this ( funeral dir	ion: To	1 Yes 2 You  27. Manuar of Death  1 Natural 5 Pendin	28a. Date of Inj (Month, Da		R/Outpatient 28b. Time of Injury	28c. Injur Wor	y at k?		dence 6 Ot how injury occur		fy)
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To	2 Accident Invest 3 Suicide 6 Could 4 Homicide detern	igation I not be mined 28e. Place of In building, e	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office	Yes 2 □No	28f. Location (Sity or Tox	Street and Num vn, State)	ber or Rur	al Route Number,
AYTYN VIO	e Hospital 124 hours a e Funeral	Medical C	29a. Certifier 1 Certifyl (Check only one) 2 Medica	ng Physician: To the best Examiner: On the basis and manner st	of examinati	rledge, death on and/or inv	occurred at the ti estigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and n date and place	nanner as , and due t	stated. o the cause(s)
7		Me	29b. Signature and title of certific		2	unt-	29c. Licens	065 18	32	29d. Date signe	ed (Month,	Day, Year)
	3		30. Name and address of person					-0.1 A	0-	I In en 1		* * * * * * * * * * * * * * * * * * * *
_	0		SIMA NOURA	NI-ZENUZ	MD	1310	DOUTH	EKN AVE	DE V	VASHING	TON	D.C. 20032

Registrar

AUG 0 8 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEN THE PROPERTY OF THE STATE OF MARYLAND AND State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lee Sr Otis 0 **Physician** 02 200 /Medical ogation of Death Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1**X** M 2 ☐ F Hours 148-09-9114 Yrs. Director 90 03 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f short must be notified at ∏Yes 2□No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 North Mt. Olivet Lane 21229 U.S.A. Funeral item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mi 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married X Married 1 Yes 2 ☐
If Yes, Give
Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade na Accounting Clerk В & O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lee-wife 16 North Mt. Olivet Lane, Baltimore, Md 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Garrison Forest Vet 8/11/08 Owings Mills, Md 21. Si matu 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or composhock, or hear vailure. List only o Do not enter the mody of dying, Juch as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed physician and s the burial-transit Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) P.0. ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown condition is contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe Division or Vital Be Was case referred to m examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 N 1 ☐ Inputient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? i or Attending Patter death.

Director; After 1 28d. Describe how injury occurred (Month, Day Year) 1 Natoral 5 Pending investigation 2 Accident 1 Yes 2 No the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I Hospitai 29a. Certifier Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature nd title of cer 29d. Date signed (Month, Day, Year) State 8 AUG 0 Registrar

2008 25580 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Craig Lyles Certificate of Death 1- For State Reg. No 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day August 4, 2008 ysician/ 0009 hrs Me Éxaminer Craig Lamont Lyles c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital 8 Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Country) **Funeral** Months Days Hours <del>09/</del>23/1985 22 Director 220-08-7856  $_{1}$   $\chi_{M}$ 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 X Yes 2 No Baltimore n/a МП 28a-f show once. more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Citizen of What Country? Director 10f. Zip Code United States 10e. Street and Number "natural", or items 23a or 28a-Examiner must be notified at 21213 1810 North Dallas Street 0/2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 X Never Married 2 Yes Specify: Black Yes 2X No specify. f Yes, Give Yea 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 2 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+ Elementary/Secondary (0-12) Home Improvement Laborer the Medical q 18. Mother's Name (First, Middle, Maiden Surname) other 17. Father's Name (First, Middle, Last) Peggy Yvonne Ratliff Ricky Ricardo Lamont Lyles cvent, is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3725 Ellerslie Ave APT 306 Baltimore, MD 21218 19a. Informant's Name/Relationship (Type, Print ) Peggy Ratliff/ Mother nt: If item 27 is r other traumat 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, MD crematory or other place)
Trinity Cemetery 08.11.2008 3altimore, Cremation 3 Removal from State 1 X Burial 2 permit. Pages
Department of
Important: It Other Specify Donation 5 Carrend Addess of Bolly lass Funeral Service P.A. 1701 McCulloh St. Baltimore, MD 21217 21. Signature of Funeral Service Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a Part I. Enter the disease, or compression failure. List only one cause on each line Between Onset and sician Death (Medical Acute Asthma Attack Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and X AMENDED 8 per fh g882 8-8-08 23a 27 per me g883 9 Physician/Medical X UNPENDED ned by the attending physician detached for use as the burial -23d. Date of delivery The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Day Year 3 Ectopic pregnancy 3b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 ✔ Unknown 5 24b. Were autopsy findings available 24a. Was an Completed Records, pnor to completion of cause of autopsy death? performed? has 1 🗸 Yes ✓ Yes 2 No. page 2 certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. this certifi 25. Was case referred to medical **Division of Vital** Other<sub>4</sub> Be Other Nursing Home 5 examiner? Hospital: 1 Inpatient 2 PER/Outpatient 3 1 V Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? After th 28a. Date of Injury 28b. Time of Injury 27. Manner of Death (Month, Day, Year) Certification: Yes 2 No 1 X Natural 5 Pending Director: . 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Could not be Suicide determined he Funeral D Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 4, 2008 Q.C.M.E. Ca 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State

Registra

Zabiullah Ali, M.D.

31. Date filed (Month, Day Year)

111 Penn Street, Baltimore, MD 21201

ORIGINAL

Assistant Medical Examiner

2008

32 Registrar's Signature

**OCME** 

Box 68760, P.O. Division of Vital Records,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 6, 2008 10:50 AM Elizabeth Mary Minardo 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Esther's Place Assisted Living Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 8, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Hours 1 □ M 2 🖺 F Days 219-50-5683 93 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at MD. Baltimore Dundalk 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 42 Liberty Park Way 21222 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 'natural", or 1 ☐Yes 2 No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any Injury or other traumatic event, the Magnice. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Harcarik Mary Tirpak ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Endryas 9 Weyfield Court, Rosedale, Maryland 21237 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 2008 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Of Jesus 21. Signature or Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P 7110 Sollers Point Road, Dundalk, M P.A. MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Spiration disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Viabetes 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy Fibrillation perform Atria 2 🗆 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Sother (Specify) ASSISTED Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box hen xander 31. Date filed (Month, 0 8 2008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

25581

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 25583

Tennie McL	.endon			Maryland / Departn	nent of	Health and I	Mental Hyg				
_		R	For State egistrar	Centil	cate of	Dealli ———	12	Reg. N . Date of Death	Ю.	3	. Time of Death
_	ysicia		. Decedent's Name (First, Middle, Last)	1. 10.			l	Month Da August 3, 200	y Y 08	ear	1614 hrs
Mec. ≟>	xamin		a. Facility Name (if not institution, give st	Lenaon	41	o. City, Town, or Lo		, luguet e,		y of Death	
			University Hospital	reet and number/		Baltimore		24 F		NIA	
			Social Security Number 1 6. Sex	7. Age (In yrs. last t	oirthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth (N	M/DD/YY	YY) . Birth	place (State or Foreign
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	any		Jsual Residence of Decedent  Oa. State 10b. County	10c. City, Tov	wn or Location	on					10d. Inside City Limits
_	W 20		ALLA NIA	1//	ashi	naton	D.C.				1 Yes 2 No
yland	ts J-1	핡	10e. Street and Number	VVC	~ III	10f Zip Code		10g.	Citizen of	What Count	ry?
Mar	ms 23a or 28a-f show be notified at once.	Director	FILM 12th Ct	raat		2001	1		4	IS A	
ta At	23a c		5406 13 3 1 11. Marital Status	12. Was Decedent Ever in U.S.	13. Wa	Decedent of Hispa	anic Origin? (Spe	ecify Yes or No-			an Indian, Black,
ath wi	tems st be	Funeral	Never Married 2 Married	Armed Forces?	If Yo	es, specify Cuban,	Mexican, Puerto F	Rican, etc.)	\ v	hite, etc.	
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5-0036 iled within 7	tygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)	1	. (	1	8. Mother's Name	(First, Middle, Mai	den Surna	(/ ·	
215	ked o	Be (	Thomas Her	iderson Wi	right		Carr	1 P. B.	Ka	NKIY Town State	Zin Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	ment of Health and Mental Hyglene. Iant: If item 27 is warked other than "natural or other traumatic event, <u>the Medical Exami</u> n	2	19a. Informant's Name/Relationship (Typ	De, Print) (nephew)	19b Mailin	Address (Street	and Number or R	Rural Route Number	/L	MA State	21207
<b>S</b> 8 8 9	h and 27 is umat		Mr. William	1. Curtis	611	1 Long	ahill 1	Date I	20c Locat	ion - City or	Town, State
e, <b>a</b>	Healt item		20a. Method of Disposition	Removal from State 20b. Pla	ice of Dispos matory or ot	ition (Name of cem her place)	8/12	/		1	1 001
10 r	nt of			For	tlin	colo Ce	m, l'	42008	Blac	dens	burg. Ma.
Baltimore, Permit. Pages I and	ortan ortan ry or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	ee ( )	22.	Name and Address	of Facility	ineral	Hom	o PA	
Ba Ba	in in Dep	- 1	Charle L	KUNN	127	22 W. No	IF TH AVP	Balt	S. Me	1-1-21	16
_	sician		23a. Fart I. Enter the disease, or como	cations that caused the death.	o not enter	he mode of dying,	such as cardiac o	r respiratory arres	t, shock, c	or heart	Approximate Interval Between Onset and
/Me	edical		Immediate Cause (Final disease a.)	n ine. Head Injuries complicatir	ng hyperte	ensive atheros	clerotic cardio	ovascular dise	ease		Death
Exar	miner			Due to (or as a consequence of):							
			Sequentially list conditions, b.								
		ner	if any, leading to immediate [ cause. Enter Underlying Cause	Due to (or as a consequence of):							
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of a	sici	Jed	IF FEMALE:	23c. If yes, outcome of pregn						ate of deliver	
Records, P.O. Box 68760 The law requires that the death certificate	ng pł as the	ian/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth		etal death 3	Ectopic pregn	ancy	Mo	nth	Day Year
th cer	attendi for use	:5	1 Yes 2 No 9 Unknown	4 Pregnant at time of dea	<sup>ith</sup> 5 (	Other (Specify)					
e deal	the ar	≥		9 Unknown contributing to death but not re	culting in the	underlying cause	given in Part I.	23e. Did to	bacco use	contribute to	o the cause of death?
Pa io	signed by t	A 참	Part II. Other significant conditions		Suiting in the	diddilying decad	5	1 Yes	2 🗸 N	o 3 Pro	obably 4 Unknown
<b>□</b> ires t	sign d be d	1 5	Chronic obstructive pulme	onary disease				24a. Was a	n	24b. Were a	autopsy findings available
regu	has been 2 should	Completed						autop: perfor	sy	prior to death?	completion of cause of
eco e law	te has							1 ✔ Yes		1 🗸 '	Yes 2 No
<u>~</u> =	tifica or, pa	ij				26.Plac	e of Death (Check		_		
icia icia	this certificate	Ba	examiner?	Hospital: 1 🗸 Inpatient 2	ER/Outpatie				Residence		er:
of Vital Records, P.O.	ter th	٦.	27 Manner of Death	28a. Date of Injury	28b. Time o		ury at Work?	28d. Describe t	now injury	motor vel	hicle collision while
nd in G	th. For	Cortification.	1 Natural 5 Pending	(Month Day Year) Aug 3, 2008	1309 hrs	1	Yes 2 ✔ No	enroute to h	ospital i	in ambula	ance
Sic	r dea	2	2 Accident Investigat 3 Suicide 6 Could not	28e. Place of Injury - At he	ome, farm, st	reet, factory, office	building, etc.		****		Rural Route Number, City
Division tal or Attendi	s after s afte	1	3 Suicide 6 Could not determine	d (Specify) Local Stree				Cathedral Str	eet at We		Street, Baltimore, MD
- Les	To the Hospital or Attending Trystam. within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ا د		ian: To the best of my knowled	ge, death oc	curred at the time,	date and place, a	nd due to the caus	se(s) and r	manner as st	tated.
a i	hin 24 the F	Modical	(Check only one) 2 Medical Examine	r:On the basis of examination a	nd/or investi	gation, in my opinio	on, death occurred	at the time, date	una piace	,	
	To T	3 2	29b. Signature and title of certifier	and manner stated.			nse number		29d. Da	ite signed (A	Month, Day, Year)
	23)	1		1/1		0.0	C.M.E.		Augu	st 4, 2008	3
1	15 4		30. Name and address of person who	complied cause of death (Item	1231)	100			1		
10		Ť	Zabiullah Ali, M.D. Ass	istant Medical Examiner	111 P	enn Street, Ba	iltimore, MD 2	21201			
				32. Legistrar's Signat		7		(	CME		
	Reg	Stat istra	# 110 <b>#</b>	Mingues de							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2008 25583

	1	For State Registrar			,	Cer	tificate of		R	eg. No.	. 0 0 0	2000
Physician /Medical	L	Bruce	(First, Middle, Last)			Mi			2. Date of Dea Month AVGUST	Day	QOO'S	3. Time of Death 4:39A M
Examiner	4	a. Facility Name (If	not institution, give st HOPICINS	BAYVLE	W		4b. City, Town, G	or Location of Death	h	4c. Cou	inty of Death N	/A
Funeral Director		Social Security Nu 213-32-04	149 XX	M 2□F 7. A	ge (In yrs. la 74	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day Jan • 2	5,1934	9. Birthi Cour Ind	place (State or Foreign ntry) iana
yland	-	Jsual Residence of I 0a. State	10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
rith the Mar or 28a-f sl be notified Director	-	laryland	Balti	more				Dun	dalk			1 ☐ Yes 22 ☐ No
a or 2 I Dire	1	0e. Street and Num	dams Road				10f. Zip Code	222			of What Cour	
permit. Pages 1 and 2 should be filed within 72 hours after death with the maryland Department of Health and Mental Hydram "natural", or items 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is it is involved in the confilted at once.  To Be Completed by Funeral Director		1. Marital Status 1 Never Marrie 3 Widowed 4	ed 2 🔀 Married	2. Was Decedent Armed Forces' 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates:	? 1 No			Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. [	Race - Ameri Black, White,	can Indian,
ygiene.  ber than "natural"  t, the Medical Ex	-  -		15. Decedent's Educ fy only highest grade			16a. Deced	lent's Usual Occu kind of work done OO NOT use retire	during most of wor	rking	16b. <b>K</b> in <b>d</b> o	of Business/In	
ygiene ygiene tt, it.	_	12 Years	5 4	Years	0.,	Larg	e Case	Manager				l Govt.
Mental H arked ott atic even		7. Father's Name (F	First, Middle, Last)				·		me (First, Middle, Ann Sha		name)	
and 2 sind salth and 27 is ma er traum			me/Relationship <i>(Typ</i> ephine C.		Vife)			t and Number or R Road Dun				
ges 1 a t of He if item or other	2	20a. Method of Dispo	osition	emoval from State		ace of Dispo metery, cren	sition (Name of natory or other pla	ace)	Date	20c. Location	on - City or To	own, State
ir. Pag irtmen ritant: njury		4 Donation	5 ☐ Other (Specify)					Corp. 8/8			on, Mai	
Deparation of the control of the con		21. Signature of Pur	neral Service Liconee			22	Duda-Rud 7922 Wie	ess of Facility R Funera Se Ave. I	l Home of	f Dund	dalk, I	Inc. 21222
Physician		shock, or hear Immediate Cause (F disease or condition	e disease, or complic t failure. List only one Final	ations that cause cause on each	line.	Do not ent						Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		Due to (or as	s a consequi	ence of):	pirator	y failu	12			6 weeks
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner		Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	ditions, nediate hying hying njury c.		s a consequ ON s a consequ		nic ven	y failu	ure			6 weeks 4 weeks
d by the attending petached for use as terached for use as terached for use as the Physician/Mec		IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	ac. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3[	Ectopic pregnar Other (specify)	ncy		23d.	. Date of delive Month	very Day Year
signed by the able detached be detached by Physic		Part II. Other signifi	cant conditions con	ributing to death	but not resu	Iting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
s been si should b									1 🗆 Y	es 2 N	lo 3∏ Pro	bably 4 🗆 Unknown
ician: The law requir certificate has been s ector, page 2 should Be Completed									24a. Was autop perfor 1 □ Yes	sy	4b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
s certif		25. Was case referrex examiner? 1 ☐ Yes 2 ☑ 1	·	ospital:	tiont 2 🗆 I	=P/Outpaties	nt 3 DOA	thor	eath (Check only on the state of the state o		Othor (Gran	. A.
nding Physician: th. After this certifica funeral director, p	-	27. Manner of Death	1	28a. Date of In	iury	28b. Time o	28c. Inj		28d. Describe h			пу)
ital or Attending Physician: rs after death. al Director: After this certification by the funeral director, rectification: To Be C		1	5 ☐ Pending investigation 6 ☐ Could not be determined	28e. Place of Ir		me, farm, str		□Yes 2 □No	28f. Location (S		lumber or Rui	ral Route Number,
To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical		29a. Certitier	1 ☐ Certifying Phys 2 ☐ Medical Examin	ician: To the bes	st of my know	vledge, deat			ce, and due to the	cause(s) an		
To the within 2 To the comple		29h Signature and	title of certifier Ma M. K	Peloyn		M·D.	_	se number S-000			igned (Month	
8.41			ess of person who cou									

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

		Please Type of P State of AMEND I	rint in Black Maryland / D TEM#2, per	Indelible ink perfit 688, epartment of I	2, <b>Ensure All</b> 2,8713/08,w Health and Me 8/18/08,ws	<b>Copies A</b> ental Hygie	re Legible.	25501.
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Annie L. Mille		Sertificate of		Date of Death Month 08	Day Vear	3. Time of Death 6: 30pm M
Exami Funeral Director	ner	241-40-8162 1□M 2 🗐 🖡	Age (In yrs. last birth	Balti	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, 1)	4c. County of Death  (ear)  1929  9. Birth  Cou	
Aaryland f show	JO.	Usual Residence of Decedent  10a, State  10b, County	10c. City, Town	or Location	4.5			10d. Inside City Limits 11√2 Yes 2 □ No
with the Na or 28a-	Director	MD NA  10e. Street and Number	Dai	10f. Zip Code	1016	100	g. Citizen of What Cou	intry?
filed within 72 hours after death with the Maryland Hygiene.  Whysiene.  Whys	by Funeral	3108 Mondawmin Ave   12. Was Deceded Armed Force   1	es? <b>∑</b> No	13. Was Decedent of I If Yes, specify Cub	1216 dispanic Origin? (Specian, Mexican, Puerto Ri	fy Yes or No- can, etc.)	U • S • A •  14. Race - Amer Black, White,  Specify: E	ican Indian,
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagnes.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4  10th grade na	or 5+)	Decedent's Usual Occup Give kind of work done life. DO NOT use retire mestic Wo	during most of working d)	16	Sb. Kind of Business/Ir	
uld be filed Mental Hygi arked other	To Be Co	17. Father's Name (First Middle Last) Willie Hollard	20		18 Mother's Name (in Rosa Rose Lee	First, Middle, Ma	niden Surname)	
and 2 sho saith and n 27 is me		19a. Informant's Name/Relationship (Type. Print) Willie Mae Miller-Dau		Mailing Address <i>(Street</i> 08 Mondaw	and Number or Rural i	Route Number, G Ba <b>lti</b> n	City or Town, State, Zinore, Md	<sup>ip Code)</sup> 21216
Pages 1 atment of He tant: if iten		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	20b. Place of C cemetery, King	Disposition (Name of crematory or other pla Memorial	Park 8/12	-   -	oc. Location - City or T	
permit Depart Import any in		21. Signature of Funeral Service Licensee	psw	22. Name and Addre March F/H 4300 Waba	West	Baltimo	ore, Md	21215
Physician /Medical Examiner			h line.	r	ng, such as cardiac or i	respiratory arres	t,	Approximate Interval Between Onset and Death 15 Mon tu 5
eath certificate be executed ettending physician and for use as the burial-transit	ical Examiner	cause. Enter Underlyin. Cause (Disease or injury that initiated events c.	as a consequence of					
Attending Physician: The law requires that the death certificate refeath.  sctor: After this certificate has been signed by the ettending phys by the funeral director, page 2 should be detached for use as the	Physician/Medica		h 2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy		23d. Date of deliv	very Day Year
equires that en signed to	b	Part II. Other significant conditions contributing to deat Coronary Or tery of	h but not resulting in t	he underlying cause given the course of the courses to	ren in Part I.		cco use contribute to	the cause of death?
n: The law re ficate has be r, page 2 sho	Completed	Heart Failure, t	lyportens	am, Di	abetes	24a. Was an autopsy performe 1 □ Yes 2 [	prior to co	opsy findings available ompletion of cause of
hysiclar this certi al directo	To Be		atient 2 ER/Outp		4 LI Nursing Home	5 Residen	ce 6 ☐ Other (Spec	ify)
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of (Month, investigation determined)  28b. Place of building		ury Wor	lYes 2□No	d. Describe how f. Location (Stre City or Town,	et and Number or Ru	ral Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the base and manner.	s of examination and	death occurred at the ti or investigation, in my	me, date and place, an opinion, death occurred	d due to the car at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
To the within to the total to the total to the the complex complex complex to the total total total to the total total total to the total	M	29b. Signature and title of certifier  Ace Co	Physic	cra 29c, Licens	52544	A		2008
		30. Name and address of person who completed cause of Benjamin S. Lee, m.D.,	700 Ga	upe, Print)  Eipe Rd#	204, Ca	tonsvil	le uo	21228
Regist	_	31. Date ded (Month, Day, Year) 32. Rég AUG 0 8 2008	istrar's Signature	14/12				
HMH 17 Rev 1/2	∠001	The state of the s						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 = State Registrar		Cei	rtificate of	Death	R	leg. No. 2UU	8 25585
			1. Decedent's Name (First, Middle, L					2. Date of Deat	th	3. Time of Death
	Physici /Medio		Elwood	Miller				AU405F	Day Yea	
1	Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death	,	4c. County of D	eath
			Hurbor Hospite	-1			imore			
	Funeral		5. Social Security Number 6.	457 14 00 5	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. l	Birthplace (State or Foreign Country)
	Director		115-26-0018		77 Yrs.			02 08	31	NC
	and and		Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or Lo	cation				10d. Inside City Limits
	/anyl	5	MD NA		Balti	more				1 XYes 2 No
	the Management 1883	<u>5</u>	10e. Street and Number		24.02	10f. Zip Code		1	Og. Citizen of What	Country?
	3a or	Funeral Director	2906 Denham C	ircle Sout	h	1	1225	-	U.S.	-
	ms 2	Jera	11. Marital Status	12. Was Decedent Eve		1	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-		merican Indian,
9	or ite		Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				Rican, etc.)	Black, W	
03	72 hours after death with the Maryland natural", or items 23a or 28a-f show dien Exacting to trofffind at	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🙀 No	Specify:		Specify:	Black
21215-0036	72 ho	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a. Deced	dent's Usual Occup	nation during most of work d)	ina	16b. Kind of Busine	ss/Industry
121	/ithin ne. <b>han</b> '	ם	7th grade	College (1-4or 5+)		DO NOT use retired Laborer	d)		Various	Johs
2	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exaction of		17. Father's Name (First, Middle, Las			JUDULUL	18 Mother's Nam	e (First Middle I	Maiden Surname)	
Maryland	d be f ental	Be c	The state of the s	,,					vialdon Garnamo,	
$\mathbf{\Sigma}$	thoulk nd Me mark mati	2	Robert Miller  19a. Informant's Name/Relationship	(Type Print)	19h Mailir	na Address (Street	Emma Ha		r, City or Town, State	e Zin Code)
Z	d 2 s Ith ar 27 is trau		Elaine Wills-N		1				Baltimor	
ē,	tem tem		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City	
no	ages ent of rt: If i		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cemetery, cren Metro Cr			/6/08	Baltimo	re. Md
Baltimore	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Service Lic					0,00		20,
ä	permi Depar Impor any Ir		Palebai )	5 K.		Name and Addre		Dalti	mara Ma	21215
			23a. Part 1. Enter the disease, or co	mplications that caused the					more, Mo est,	Approximate Interval Between
	Physician		shock, or healt failure. List on Immediate Cause (Final	5.75 40	15. 0	(.	0	green .		Onset and Death
	/Medical		disease or condition resulting in death)	a. Me tus fu Due to (or as a co		-024606	Cancer			
7	Examiner		1		, , , , , , , , , , , , , , , , , , , ,					
	70 ==	ner	Sequentially list conditions, if any leading to immediate	b. Due to (or as a co	onsequence of):					
	nd nd transi	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
68760,	e exe		resulting in death) Last	Due to (or as a co	onsequence of):					
876	cate by shysic the b	Medical		d						
× 6	ertific ding p	Me	IF FEMALE:	00-16		0.5				32
Bo	ath c attend or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐	☐ Fetal death 3 ☐	Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
Ö	the de	Physician	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at tin 9 ☐ Unknown	ne of death 5 L	Other (specify) _				
σ.	that t		Part II. Other significant conditions	contributing to death but n	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute	e to the cause of death?
Records,	uires I sign Id be	d by				, 0		1 □ Ye	es 2□No 3□	Probably 4 Onknown
00	v req beer shou	ete				·		24a. Was a	OAh Moro	autonou findingo quallable
Re	he lav e has ge 2	Completed						autons	sv prior	autopsy findings available to completion of cause of
Vital	ifficat or, pa		25. Was case referred to medical				00 81(5)	perform 1 □ Yes		es 2 Mo
>	/sicia s cert	o Be	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatier	ot 3 🗆 DOA Oth	er: 4 Nursing Ho		ence 6 Other (S	?nnoi6.)
of	g Phy er thi	i i	27. Manner of Death	28a. Date of Injury (Month, Day, Ye					ow injury occurred	вресну)
Ö	ath. r: Aff	atio	1 Natural 5 Pending 2 Accident investigati		ear) Injury		Yes 2 □No			
Division	er de recto by th	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		- At home, farm, stre	et, factory, office		28f. Location (St City or Town		Rural Route Number,
	talonrs aft	Cer								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical Ex	Physician: To the best of naminer. On the basis of ex	ny knowledge, death	occurred at the til	me, date and place	and due to the o	cause(s) and manne	r as stated.
	the hin 24 the F	Medical	one)	and manner stated	1.					
	wit 70	2	29b. Signature and title of pertifier	1		29c. Licens		2	29d. Date signed (Mo	onth, Day, Year)
	0		Mul		Q	400	U 4 7 7 7 C		August 1	, 2008
	")		30. Name and address of person wh	completed cause of deat	h (Item 23a) (Type,	Print)	7.11		1141) 71	125
	Sta	to	David Scherage 31. Date filed (Month, Day, Year)	D Completed cause of deat	Signature	over st	Dalt	mc-e,	MU 21	
	Sta Registr		AUG 0.8.200	8	H Corn	العرائع				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2008 8:30 A. Eva McEwen 5 Eulalia August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8919 Liberty Lane Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 2, Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min. Months 1 □ M 2 🖾 F 91 476-16-5201 Minnesota **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Modical Examinar must be natified at Director 1 ☐ Yes 21 No Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8919 Liberty Lane 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ☐Yes 2 X If Yes, Give Year or Dates: 2 🔀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of the Hatilh and Mental Hyglen. Important: If item 27 is marked other than any Injury or other traumatic enter that once. Teacher Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Kowalczyk Elizabeth Harmonick ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean E. McEwen / Daughter 9521 Woodley Avenue Silver Spring, Maryland 20910 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Snelling
National Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) August 11, 2008 Minneapolis, Minnesota 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses M00896 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Urosepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Little bridging Cause (Disease or injury Due to (or as a consequence of): Hypertensive Card<u>i</u>ovascular Disease with Congestive Heart Failure Examiner The law requires that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter for u 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) signed by the a d be detached f Ö 1 ☐ Yes 2 🖾 No g Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 2 X No 1 ☐ Yes 2 No 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{X} \) Other (Specify) \( \text{Living} \) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the I within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D35579 August 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Jaffe Miller, M.D. 8218 Wisconsin Avenue Suite 305 Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2008 BALL. Registrar AUG 0 8

			1 - For State Of IVI	aryiand / Depa <i>Cei</i>	rtificate of t	neaim and iv Death	rentai myg Re	eg. No. 200	8 25587
	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Death     Month	-	3. Time of Death
	/Medic		Gerard Thomas McKenna				8	3 200	
	Examin	er	4a. Facility Name (If not institution, give street and number)  FYANKLIN SQUARE HOSPIFAL		4b. City, Town, or Baltimo	Location of Death		4c. County of Dea	
X	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
	Director		218-54-4695 <sup>1</sup> ∏ <sup>M 2□ F</sup>	58 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb 4,	1950 Mai	yland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	MD Baltimore	Nott	ingham				1 □Yes 2 □ No
	or 28	Dire	10e. Street and Number	<u> </u>	10f. Zip Code		10	0g. Citizen of What C	ountry?
	s 23a	ral	25 Bartley Court			1236		USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Evand are must be inclifted at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 ☒ If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 □Yes 2🌠 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
5-0	72 ho	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of worki d)	ing I	16b. Kind of Business	/Industry unk
121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or s	5+) Iife. I	DO NOT use retired programn				
<b>Q</b>	filed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)		program	18. Mother's Name	(First, Middle, N	Maiden Surname)	
/lan	ruld be filed withi Mental Hygiene. arked other than atic event, tra M	To B	Bernard Joseph McKenna			Catherin	ne Eliza	beth Moore	<u>.</u>
Maryland	2 should and Mer is marke raumatic	ľ	19a. Informant's Name/Relationship (Type. Print)		-			City or Town, State,	Zip Code)
	s 1 and 2 of Health item 27 i		Barbara Ireland/daughter  20a. Method of Disposition			rive Towso		21286 20c. Location - City or	Town State
Baltimore,	Page nent o ant: # ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	20b. Place of Dispo				•	
Ba	permit. Departr Importa any Inju		marilla	ector S	State Ana Baltimore	tomy Boar , MD 212	d 655 W.	Baltimore	e Street
En	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li Immediale Cause (Final disease in condition resulting in death)	if the death. Do not entine.  a consequence of):	er the mode of dyin	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner		EVAIN 1	ancer					1 year
	ted sit	nine	Sequentially list conditions, and any lacting Limmaclatic cause. Enter Underlying Cause (Disease or Injury that initiated events	a consequence of j					I year
,	tificate be executed tg physician and as the burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as	a consequence of):				<del> </del>	1 4 661
68760,	ate be hysicia he bur	ledical	d						
			IF FEMALE:						
.O. Box	The law requires that the death cer ate has been signed by the attendin age 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	2 Fetal death 3	Ectopic pregnance Other (specify)	у		23d. Date of de Month	Day Year
ords, P.	w requires that s been signed I should be deta	by	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.			o the cause of death?  Probably 4 🗆 Unknown
		Completed					24a. Was ar autops perforn 1 □ Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
Vital		Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpution		Oth	26. Place of Death			
of		n: To	27. Manner of Death 28a. Date of Inju	ent 2 ER/Outpatier	28c. Injur	y at		w injury occurred	ecify)
io	Attending r death. sctor: After by the funer	atio	1 Natural 5 Pending (Month, Da 2 Accident investigation	ıy, Year) İnjury	M 1 🗆	Yes 2□No			
Division	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injuding, et	ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or F , State)	lural Route Number,
	ne Hospital or a n 24 hours after ne Funeral Dire pletely filled in L	ledical	29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the best 2 ☐ Medical Examiner: On the basis of and manner st	of examination and/or in	h occurred at the tir vestigation, in my o	me, date and place, pinion, death occurr	and due to the cred at the time, d	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		29c. Licens		29	9d. Date signed (Mon	
			Con Cenja MD			6878		8/3/0	8
			30. Name and address of person who completed cause of a DY. RAVI RANAN GUDD FRANKI	0 -		more MI	7173	7	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	THE PORTS	HINE PAIR	- 6163	1	_
	Registr	ar	AUG 0 8 2008	the SU STATE					

McKenna, Gerard

			For	State of Maryland				Mental Hy	giene		
			1 - State Registrar		Ce	rtificate of	Death		Reg. No. 2	008	25588
	Physici	an	1. Decedent's Name (First, Middle, Last	")				2. Date of De Month August		Year	3. Time of Death
and a	/Medic		Ann C. Michener  4a. Facility Name (If not institution, give	street and number)		4h City Town o	r Location of Death	August	- 1	unty of Death	5:05 AM <sup>M</sup>
	Examin	ier	Gilchrist Hospid	· ·		Towson				1timor	e
	Funeral Director		5. Social Security Number 6. Se 15–20–7180	x 7. Age (In yrs. Is ☐ M 2  F 83	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Dec 20,	y, Year)	9. Birthp Coun Kans	* /
7			Usual Residence of Decedent					pec 20,	1,21		
	laryla shov	'n	10a. State 10b. County  MD Baltimor		r, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2√ No
	the M 28a-f notifie	Director	MD Baltimor	e (	Jockey	sville			10g. Citizen	of What Coun	
	ath with s 23a or rust be	ral Di	13801 York Road #				21030			USA	
036	e filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or items 23a or 28a-f show ont, I'm M. dical Evaminer must be notified at vent, I'm M. dical Evaminer must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  ☐ Yes 2 MNo If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, e ecify: Whi	etc.
21215-0036	ithin 72 ho ne. <b>nan "natur</b> Worteni	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of work d)	sing	16b. Kind o	of Business/Inc	dustry
2	led wi lygier her th		12	4		homemak		- /Final Baidella		home	
Maryland	d be filed antal Hyg ced other c event,	Be c	17. Father's Name (First, Middle, Last)  James Russell Cra	abtree			18. Mother's Nam	e (First, Middle, ta Clar		name)	
Z.	i 2 should be f h and Mental I i s marked oi raumatic eve	욘	19a. Informant's Name/Relationship (7)		19b. Maili	ng Address (Street	and Number or Ru			wn, State, Zip	Code)
	ss 1 and 2 should be of Health and Mental I Item 27 is marked o r other traumatic eve		John Michener/spo			_	oad #H1 C		-	•	
፵	Pages 1 anent of He ant: If Item ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ I  4 ☒ Donation 5 ☐ Other (Specify,	Removal from State	ace of Dispo emetery, crea	osition (Name of matory or other plac	ce)	Date	20c. Locati	ion - City or To	wn, State
Balti	permit. Pages Department of Important: If I any injury or once.		21. Signature of secretary relatives Licens	ade hitector	Si Ba	2. Name and Addre cate Anate altimore,	ss of Facility Omy Board MD 2120	655 W.	Ba1ti	lmore S	treet
			23a. Part Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death				·	rrest,		Approximate Interval Between
100	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. LEULEN  Due to (or as a consequ	NIA						Onset and Death
and the	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ							
	xecuted and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Extern Joyling Cause (Disease or injury that initiated events resulting in death) Last	c	ence of):						
8/60	icate be executed physician and the burial-transit	dical E		d							
O. Box 6	w requires that the death certifice been signed by the attending I should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknow	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3[	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	ry		23d	. Date of delive Month	ery Day Year
ري ح	s that med b	y Ph	Part II. Other significant conditions co				en in Part I.	23e. Did t	obacco use	contribute to th	ne cause of death?
ğ	equires en sig ould ba	ed b	the multiple	. Mycloma-	nista	ry of		1 🗆 '	Yes 2□N	lo 3□ Prob	Dably Unknown
<b>~</b> ~	The law rete has be age 2 sho	omplet	Breast can	ice, his	tory	OF.			osy rmed?	prior to cor death?	psy findings available impletion of cause of
VITal	rian: artifica ctor, p	Be C	25. Was case referred to medical				26. Place of Deat	1 □ Yes th (Check only o	2 No   nne)		2 No
O	hysic his ce il direc		examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatie	nt 3 □ DOA Oth	er: 4 🗆 Nursing He	ome 5 🗆 Resi	dence 6	Other (Specif	y) HOSPICE
בי	iing P	i.i	27. Manner of Seath 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor	k?	28d. Describe			
DIVISION	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st		Yes 2 □ No	28f. Location ( City or Tox	Street and N vn, State)	lumber or Rura	al Route Number,
:	e Hospita 124 hours e Funeral letely fille	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	/sician: To the best of my knowiner: On the basis of examinat and manner stated.	wledge, deat	th occurred at the tinvestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) an date and pla	nd manner as s ace, and due to	stated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	Pauller	0	29c. Licens	56 43		29d. Date si	igned (Month,	Day, Year)
			30. Name and address of person who c	ompleted cause of death (Item	23a) (Type,	Print)	Atown A	lod/P	rof	M~~ N	W 21204
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure				ا است		0001
	Registr	ar	AUG 0 8 200	8 Resign 14	A STATE OF THE STA						
DHM	1H 17 Rev 1/2	.001			OPIC	SINAL					
					UNIC	ALL NAME					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 1245 PM July 8005 Juanita Matthews 30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Union Memorial Hospital 8. Date of Birth (Month, Day, April 30, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. Days 1 □ M 2 🛣 F MD 61 216-48-2150 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County show th and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exa. Inc. must be notified at Baltimore 1 Nes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 IISA 530 Main Street death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐Yes 2√5 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: <u></u> 3₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Machine Operator Harte Hawks 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Johnson, Sr. Mary L. Jacobs မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lynette Zimmerman / Daughter 2003 Paulette Road; Baltimore, Maryland 21222 Health a permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/04/2008 Dundalk, Maryland Sacred Heart Cemetery Wylie Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Aicensee 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 5 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each of carrying Cause (Disease or injury that initiated events resulting in death) Last Failure Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transi Depression Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🛣 No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl autopsy perform 2. No 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 2 ☐ Accident 1 ☐Yes 2 ☐ No after death Director: / 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory in filled in both 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July -30 - 2008 Alcheikh 243 8946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11-5pital MD nemorial stimo uc 32: Registrar's Signature 31. Date filed (Month, Day, Year) 2008

State

Registrar

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 25590 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 6, Day 2008 Year Physician 7:00 Nazelrod Robert Dwight /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 9905 Berliner Place, Apt. E Middle River If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1XX4 2 □ F 64 219-40-7744 05/15/1944 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f show 1 ☐ Yes 2 KXXIo Maryland Baltimore Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 and 10 montant. The Medical Example 20 or 2 and 10 montant. 21220 U.S.A. 9905 Berliner Place, Apt. E Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2**XX**No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory 11 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Jasper Nazelrod Gladvs Macdonald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isabelle Nazelrod (Wife) 9905 Berliner Place, Apt. E, Balto., Md. 21220 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Bayview Crematory Inc 08/07/2008 Baltimore, Maryland 4 Donayon 5 ☐ Other (Specify) 21. Signature of Fineral Service Sicensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death Part 1. Enter the disease, or of molications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pencual **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 100 1 ☐ Yes

Box 68760,

or Attending Physician: The law requires that the death certificate be executed Director: within 24 hours a
To the Funeral I
completely filled

Completed Be Certification: To

Medical

Division of Vital Records.

State Registrar

DIRECTOR,

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

5 Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

sullan MEDICAL ONCOLDET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSS C. DONEHOWER, MO

Ceucer Center Tokus Hophings

all mountles

26. Place of Death (Check only one)

Other: 4 \sum Nursing Home

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

5 Pending

investigation

determined

6 ☐ Could not be

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

29b. Signature

82, Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician
/Medica
Examine

**Funeral** 

5. Social Security Number 8. Date of Birth (Month, Day, Year) Min. 1 M 2□ F Months Davs Hours 213-26-5905 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "Medical Eventines Trust be notified at once. 10a. State 10b. County 10c. City, Town or Location Funeral Director **Ellicott City** MD Howard 10e. Street and Number 10f. Zip Code 21042 3159 Pine Orchard Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 10/9 If Yes, Give 1 Never Married 2 ☐ Married 10/9/1951 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 10/9/1955 Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Security Guard** unt 17. Father's Name (First, Middle, Last) **Charles Thomas Naide** ٩ 19a. Informant's Name/Relationship (Type. Print) Sarah J. Sherman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Depation 5 ☐ Other (Specify) Aug 09, 2008 Good Shepherd Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Gentallen We MOUS 3 art1. Enter the difease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ediate Cause (Final Cardiovascular **Physician** altrosclerate d ease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physlcian: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, myleodysplasha syndrome Completed renal insufficiency 24a Was an rewrest PREUMONICS 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1XYes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natura! 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

© Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number Resident 1895-1 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Balto, NIB 21201 Owen Debown 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

2. Date of Death 3. Time of Death Month Year Naude August 05 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ba etimire ollayland Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD May 24, 1931 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? U.S.A. 14 Bace - American Indian 16b. Kind of Business/Industry Johns Hopkins 18. Mother's Name (First, Middle, Maiden Surname) Catherine Shields 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3159 Pine Orchard Lane Apt. 101 Ellicott City, MD 21042 20c. Location - City or Town, State Ellicott City, Maryland Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City. MD 21043 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

ORIGINAL

Registrar DHMH 17 Rev 1/2001

Box 68760.

P.O.

			1 - State of Ma Registrar	ıryland / D	epartme <i>Certifica</i>	nt of H <i>te of L</i>	leaith and M D <i>eath</i>	1ental Hy	gien Rea. No	200	8 25	593
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of De	_		3. Time o	f Death
	/Medic		Marie A. Primus					8-2-2	800		9:35P	M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Stella Maris		1	, Town, or ${ m Towso}$	Location of Death		40	Balto.	ath	
	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birth	hday) If Unde	er 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	I 9 B	rthplace (State	or Foreign
	Director			92 Y	rs. Months	Days	Hours Min.	11-1-1	915	Ma	ryland	
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			* === .			10d. Inside C	ity Limits
	Mary a-f sh	tor	Md. Balto.		Parkv	ille					1 □Yes	2 No
1.	or 28	Director	10e. Street and Number		10f. Z	ip Code			10g. C	itizen of What (	Country?	
P.M	ath w		2423 Lakewood Rd.			212				USA		
35	ter de item	Funeral	11. Marital Status  12. Was Decedent E Armed Forces?  1 □ Never Married   Married   1 □ Yes 2   N		If Yes, sp	ecify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecity Yes or Ne Rican, etc.)	o-	14. Hace - An Black, Wh		
9:036	72 hours after death with the Maryland natural", or items 23a or 28a-f show Alcel Examinat must be notified at		If Yes, Give   If Yes, Give   Year or Dates:		1 □Yes	2X□ No	Specify:			Specify:	White	
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	1 (	Decedent's Usi (Give kind of w	ork done o	durina most of work	ing	16b. k	(ind of Busines	s/Industry	
121	within ene. than	Completed by	Elementary/Secondary (0-12) College (1-4or 5-		Homem	use retirea	1)			Home		
8 2	filed I Hygi other ent, II	Be C	12 + 17. Father's Name (First, Middle, Last)		пошеш	akei	18. Mother's Name	e (First, Middle	, Maidei			
2008 yland	uld be Menta arked atic ev	10 B	Rudolph Herman				Anna Jo	ordan				
2,2008 9:3 Maryland 21215-0036	2 sho n and ris ma rauma		19a. Informant's Name/Relationship (Type. Print)  Jerri Buschman  DTR.	19b. I			and Number or Run Lworth Dr			or Town, State		
IST.	1 and Healtl em 27		Jerri Buschman DTR.  20a. Method of Disposition	20b. Place of (	Disposition (Na	ame of	1	Date		ocation - City o		
AUGUST Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Examination must be notified at once.		†☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Parkwo	y, crematory`or	other plac	e) !	-2008		rkvill		
altin	permit. F Departm Importal any Injul	. 19	21. Signature of Fungral Service Licensee	1 021000	1	and Addres	e of Facility		k Fi	neral l	Tome	
Ω	8 9 T 28	1. 0	Il till				lair Rd.	Nottin	ghar			
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do no	ot enter the mo	ode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximation Interval Be Onset and	tween
	Physician /Medical		resulting in death)	IMER'S	DISE	ASE						
7	Examiner			a consequence of	t):							
100	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of	f):							
V	ecute and -trans	Examiner	Cause (Disease or injury that initiated events c	a consequence of	£\.							
68760,	ificate be executed g physician and as the burial-transit		Due to (of as a	t consequence of	1).							
687		ledical	d									
Вох	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the post 12 meths?  23c. If yes, outcome 1 □ Live birth		3 ☐ Ectopic	pregnanc	v			23d. Date of o	,	V
O.	ne dea the at	ysici	in the past 12 months?  1 ☐ Yes 2 Mono 9 ☐ Unknown	time of death	5 ☐ Other (s					Month	Day	Year
٦.	law requires that the das been signed by the 2 should be detached		Part II. Other significant conditions contributing to death but	it not resulting in	the underlying	cause give	en in Part I.	23e. Did	tobacco	use contribute	to the cause of	death?
rds	quires en sigr uld be	ed by						1 🗆	Yes 2	No 3□	Probably 4□	Unknown
IE eco	law re as bee 2 sho	plet						24a. Was	an	24b. Were	autopsy findings completion of o	available
MARIE al Rec	ician: The law certificate has ector, page 2 (	Completed						perf 1 □ Yes	ormed?	<ul> <li>death</li> </ul>	s 2 No	
V. Z	sician certifi rector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie			Othe	26. Place of Deat					
PRIMUS	Attending Physician: r death. ector: After this certific by the funeral director.	n: To	27. Manuer of Death 28a. Date of Injur	nt 2 ER/Outp ry 28b. Ti	ime of	28c. Injur Work	4 🗷 Nursing Ho	me 5 ☐ Res 28d. Describe			pecify)	
PRI sion	ttending death. ctor: Aft y the fun	atio	1 1 Matural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	, rear) Inj	ijury M		Yes 2□No					
PRIMUS, MARIE Division of Vital Records,	I or Attu after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	iry - At home, farr c. <i>(Specify)</i>	m, street, facto	ry, office		28f. Location . City or To			Rural Route Nur	nber,
	spital ours a leral C		29a. Certifier 1 Certifying Physician: To the best of	of my knowledge.	death occurre	dat the tir	me, date and place	and due to the	e cause(	s) and manner	as stated	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and	d/or investigation	on, in my o	pinion, death occur	red at the time	, date ar	nd place, and d	ue to the cause(	s)
	Vithi To th	Ž	29b. Signature and title of certifier		29	9c. License				_	nth, Day, Year)	
	,		Demisarione MD			D16	619		Au	gust &	1, 2008	
	0		30. Name and address of person who completed cause of de									
	Sta	te	Corazon Soares, M. D. 2 31. Date filed (Month, Day, Year) 32. Registra	<u>≾00 Du1a</u> ır's Signature	ney Va	Lley	Rd, Timor	nium,MD	_210	193		
	Registra	ar	AUG 0 8 2008	ar's Signature	JODNA.	5						

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Elizabeth B. Peklo 3:10 AM Aug 7, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville **Baltimore Charlestown Care Center** if Under 24 Hrs. 8. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours Months 1 □ M 2 X F 93 NY 184-01-8682 **Director** Jan 4, 1915 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State r than "natural", or items 23a or 28a-f show the Me-Ical Examiner must be notified at 1 ☐ Yes 2 No Catonsville Director MD **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 715 Maiden Choice Lane U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced Year or Dates: Dute Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Huddvie Henry Behnke ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gary Peklo 3326 Rosemary Lane West Friendship, MD 21794 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug 08, 2008 Glen Burnie, MD **Atlantic Crematory** Service License 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final **Physician** disease or condition resulting in death) Dementio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unicase of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the mosphill to the mosphill to the Funeral Director: After this of the Funeral Director: After this of the funeral directors to the funeral directors. 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ten Choice In Cathonsville 32. Registrar's Signature State AUG 0 8 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

25595 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:30 AM **Dorothy Constance Poulsen** Jul 31, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia Howard Harmony Hall Assisted Living If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 □ M 2 K F Months Days Hours Director 089-12-2534 Sep 3, 1923 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 U.S.A. 6336 Cedar Lane 326 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: ģ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specity only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tomemaker 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alf Foss Bergljot Bjerke 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) Martin Poulsen 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State DVeterans Come to 4 ☐ Donation 5 ☐ Other (Specity) nature of Funeral Service Lice 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Enter the Immediate Cause (Final disease or condition resulting in death) Kenal **Physician** failure /Medical Due to (or as a consequence of): Examiner elone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSION the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specity) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 27 I No HYDROCEPHALUS 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed DEMENTIA 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an HYPOTHYROIDISM 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death ineral Director; 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 W Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) August 1st, 20 29c. License number 29b. Signature and title of certific -30469 Mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 PARKWAY A 308 NB VELLANKI. 8850 COLLYBIA 21045 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

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	0.34		Decedent's Name (First, Middle, Last	st)						2. Date of Dea			3. Tim	ne of Death
	Physici /Medic		William Richard P	rowell,	Jr.					August	05,	2008	5:1	LO A. M
	Examin		4a. Facility Name (If not institution, give		nber)		4b. Cit		ocation of Death			unty of Death		
			Brightwood Center		7 Ann //n	fa a A b fab da	lf Llod	Luther er 1 Year	TV111e  f Under 24 Hrs.	0 Date of Bird		timore		
1	Funeral Director		5. Social Security Number 6. S 218-44-5411	ex M 2□F	7. Age (In yrs. 62	. iast birthday, Yrs.	Month		Hours Min.	8. Date of Birt (Month, Day Jan. 26	1946	Balt	piace (St intry) LMOY:6	ate or Foreign
3	· ·		Usual Residence of Decedent							J 4411 2 3	,			
本道	irylan show d.at	L	10a. State 10b. County	7.		ity, Town or L								de City Limits
7 4	Be-f s	cto	Maryland N/	A	Ba.	ltimore								Yes 2 No
70 5	with the	Dire	10e. Street and Number 1207 Roland Heigh	+c 7110			10f. Z	Cip Code	L211		-	n of What Cou ted Sta	,	
b	death with the Maryland rms 23a or 28e-f show	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in L	J.S. 13.	Was Dec			ecify Yes or No-		Race - Ameri		ın.
9	after d	Fun	1 Never Married 2 Married	Armed For	rces? 2 □ No				anic Origin? (Sp Mexican, Puerto	Rican, etc.)		Black, White	, etc.	
33	o 72 hours after death with the Marylar "netural", or Items 23a or 28e-f show	Be Completed by	3 ☐ Widowed 4 🏝 Divorced	If Yes, Giv Year or Da	e Viet	nam	1 L Yes	21 No	Specify:		Sp	pecify: \	White	3
3.	"netu	etec	15. Decedent's Ed (Specify only highest gra			(Give	kind of v	ual Occupati work done dui	on ring most of work	king	16b. Kind	of Business/Ir	ndustry	
72	within ene. then	dmo	Elementary/Secondary (0-12)	College (1	-4or 5+)			use retired) Proc	grammer		BAE	Syste	ns	
Z 2	filed Hygi other	e C	17. Father's Name (First, Middle, Last)				npace		8. Mother's Nam	e (First, Middle,				
	uld be fental rked ric ev	To B	William Richard F	rowell,	Sr.			E	tta Sch	orr				
Nillian Arwell Maryland 21215-0036	and h		19a. Informant's Name/Relationship (	Type, Print)			_		d Number or Rur					
	and sealth m 27		Mr. Robert D. Pro	owell (	Son)				e Circle			,Maryla		21237
Baltimore.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Infinortant: It flem 27 is marked other then "netural", or Items 23a or 28e-1 show eny injury or other traumatic event, Ita Marical Examinat her must be confilled at once.		20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content o		State EV	Place of Disponentery, creations Full	osition (N matory of nera.	am <i>e</i> of other place) Chape	Augu 20	st 08, 08		tion - City or T t Hill		
Balt	permit. Departr Importi eny inji		21. Signature of Funeral Service Licer	1 ga	in, di	2. P	2. Name eacet 2325	ul All York I	of Facility ternativ Road I	es Fune Inonium	ral&C Mar	remation	on Ct 210	er.P.A
1			23a. 7a/1. Fit the beause, or o m stock, or it and fullule. List only	plications that co	aus the dea							1	Approx	
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	/Medical		resulting in death)	Due to (	or as a conse	quence of):	1	)	_				1	00
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a conse	quence of):								
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8760,	cate be executed physicien and the burial-transit	cai	(	d										
9	5 0 8	0	IF FCMALC											
Division of Vital Records, P.O. Box	Physicien: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fet	al death 3	∃Ectopic	pregnancy			230	d. Date of delivers. Month	very Day	Year
o.	the a	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregn 9□Unkno	ant at time of	death 5	Other (	specify)				MONTH	Day	i ear
م:	that the ed by	Ph	Part II. Other significant conditions of	ontributing to de	eath but not re	sulting in the i	ınderlyind	cause given	in Part I.	23e. Did to	obacco use	contribute to	the cause	of death?
sp	w requires to been signed should be	d by					, -			101	Yes 2□1	No 3□Pro	babiy 4	4 Onknown
S	faw rec as beer 2 shou	Completed								24a. Was	an 2	24b. Were aut	opsy find	ings available
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<u>i</u>	ticlen: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					2	6. Place of Deal			1 🗆 163	20140	
>	Physic this ce al dire	ို	1 ☐ Yes 2 D No			ER/Outpatie	nt 3□ [	OCA Other:	4 Nursing Ho	ome 5 ☐ Resid	dence 6	Other (Spec	ify)	
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<u>~</u>	lor A after Direction by	Certification:	4 Homicide determined	buildir	of Injury - At h ng, etc. (Spec	ify)	reet, racti	огу, опісе		City or Tox	vn, State)	VUITION OF FULL	rai nobie	rvum <i>ber</i> ,
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example)	ysician: To the niner: On the ba and mann	asis of examin	lowledge, dea lation and/or in	h occurre	d at the time, on, in my opin	, date and place, ion, death occur	and due to the	cause(s) ar date and pl	nd manner as ace, and due	stated. to the cau	use(s)
	o the ithin ; o the omple	Mec	29b. Signature and Alle of certifier	and man	ાન ગાંઘાસ્ત્ર		2	9c. License r	number		29d. Date s	sign <b>∉</b> d (Mopth	, Day, Ye	ar)
	F \$ F 0		NATU.					Dlo	1731	:		3/1/0	8	
	061		30. Name and address of person who	completed caus	e of death (Ite	m 23a) (Type	Print)	0	•			10/		
_	OFI		R GAW CARDEN	(MD)	0565		all	es St	(73)	to, MID	21	204		
	Sta Registr		31. Date filed (Month, Day, Year)	2008 32. R	egistrar's Sign		and the same of th	.0		/				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 01 renhallegon 200 FUNIPAL /Medical 4b. City, Town, or Location of Death acility Name (If not institution, give street and number) **Examiner** Oak Crest Care Center Parkville Baltimore B. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 92 Yrs. 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🗷 F ig 16 Wisconsin 326-03-0482 30 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Maryland Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8832 Walther Boulevard Apt. 337 21234 USA Pages 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Be Completed by 3 ₩ Widowed 4 Divorced the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Monee. Salesclerk Hutzler's Dept. Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank B. Day Eloise Stevens ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Penhallegon / Son 4323 Conifer Court Glen Arm, Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens 8/5/08 Timonium Maryland ceonard fidess (Faciliac 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition (ere brownscular accident Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ebility Sequentially list conditions, if any leading to him diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 □ Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No 24a. Was an autopsy perform 1□ Yes 2 X No Be ( 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 40052365 august 3, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boulevard Parkville Margian 21234 8806 Walther

31. Date filed (Month, Day, Year) State Registrar

32 Registrar's Signature

AUG n 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 08 **Physician** 7:20 PM /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner Towson Baltimore Spice If Under 1 Year \_ If Under 24 Hrs. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🔀 F 73 Yrs. **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1XYes 2 No Director HIMOVE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 10, Saltimore, Maryland 21215-0036 1 ☐Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, Be ပ္ 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Greene Funeral Services 21. Signatute of Funeral Service Licenseen 22. Name and Address of Facility 23a. Part 1. Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. 5151 Baltimore National Pike Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. E Teneral Director: After this certificate has been signed by the attending physician and letely filled in by the Thoratal director, page 2 should be detached for use as the burlan-transit letely filled in by the Thoratal director, page 2 should be detached for use as the burlan-transit Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 

Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? 1 Yes 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 | Nursing Home 5 | Residence 6 | Other (Specific Octoor) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ALGUST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAUN J CHANGES MA) 670 N. CHANGES C TOW SUN MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dav Year <u>Valree Jean Palmer</u> 2008 /Medical lugust 11:55 4a. Facility Name (If not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 9305 Fernwood Road Bethesda
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 ဩ F Months Days Min Hours Director 452-16-9845 October 15, 1919 Kansas Usual Residence of Decedent death with the Maryland 10a State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinational be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland | Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? Funeral 9305 Fernwood Road 20817 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Tes 2 Tes 1 Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ş 1 ☐ Yes 2 🗓 No Specify. 3 XWidowed 4 ☐ Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Lry or other traumatic event, ITe M College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ Matthiassen Happie Onev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau
once. David B. Palmer/ Son 9305 Fernwood Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, IndAugust 7, 2008 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. alk M01532 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Carcinoma to liver 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ovarian Mass 2 Months Sequentially list conditions Examiner Due to (or as a nonsequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Perneral Director: After this certificate has been signed by the attending physician and and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🔀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ <u>Coronary Artery</u> Disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2⊠No 2 🗆 No 1 □Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License numbe D35996 August\_4, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Burrell. 2730 University Boulevard, Wheaton, Maryland 20902

Registrar's Signature M.D. 31. Date filed (Month, Day, Year) State AUG 0 8 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 055 AM Xavier 2000 29 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital Baltimore City 8. Date of Birth (Month, Day, Year) June 14, 2008 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 💹 M, 2 🗆 F Hours infant Maryland Director Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Temple Hills Prince George's MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7113 Karen Ann Drive 20748 USA Funeral Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: black Specify: <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 Is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) unk Be Latricia Pratt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 Wolfe Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 N Other (Specify) in state 21. Signature of Funeral Service ROTIALO State Anatomy Board 655 W. Baltimore Street Birector Baltimore, MD 21201 Part I. Enter the disease or committations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Necroti disease or condition resulting in death) ZIM /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine (the annuagement of the contract of the contra attending physician and d for use as the bunat-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 - Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes ours after death. eral Director: After this certificate has been sig filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2XNo 1 Nnpatient 2 ER/Outpatient 3 DOA 1 Tyes ည 27. Manner of Death 28a. Date of Injury (Month, Day ) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury or Attending 1 Natural 1 Tes 2 🗌 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8ES-000 2018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Bernadette ronder 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 8 Registrar

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Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician 3.29 AM Antoinette Delores Quarles AUGUST 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAT HUSPIAN OF BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Months Days Hours Min. Director 213-58-4804 4/29/1951 57 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes X□No Director Baltimore MD Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1121 Wilson Avenue 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ▼XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. African-American 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify. Completed by Specify 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Barton Malow Finterprises Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental I Henry A. Oliver Jr. Delores Barnes ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 Wilson Avenue, Gwynn Oak, MD 21207 Edward Quarles Jr./ Husband 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages
Department of
Important: If it
any injury or o ō Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsvilles Veterans 8-11-08 Crownsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility While Finand Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) respiratory Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): physician Physician/Medical for use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ms certificate has been signed I director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Mannor of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AUGUST, 5,2008 140 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hospital KIREET AGRAWAL Sinai 32. Registrar's Signature 31. Date filed (Month, Day, Year)
AUG 0 8 State AUG 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** anda 2008 0624 AM am /Medical 4a. Facility Name (If not institution, give street and numbe 4b. Aty, Town, or Location of Death 4c. County of Death Examiner ) pains field (chter ykes ville I 9 MOII 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 27 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours -58-1702 Days Min. 1 M 2 □ F May 1946 62 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show MD Carroll Svkesville 1 ☐ Yes 2 No notifled Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with I ment of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23a or ; ury or other traumatic event, the Medical Examiner must be r 6655 Sykesville Road 21784 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: black 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) masonry mason 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Springfield Medical Records 6655 Sykesville Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important; If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Springfield Cemetery 8-8-08 4 Donation 5 Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facil Waight Funeral Home & Chapel Dauge spaight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Clause (Disease or lingury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, the burialphysiciar Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months Month Day Year 5 ☐ Other (specify) been signed by the should be detached 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Xes 2□ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performe certificate 2 🗆 N 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 25. Was case referred to medic Medical Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 1 thpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2010 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

Hospital Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Gheug

32 Registrar's Signature

Raman

AUG 08

31. Date filed (Month, Day, Year)

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

For	State	of Maryland	-				na iv	lental H	ygie	ne		2500
State Registrar			Cei	rtificate	of D	eath		0 D 1 - (1		No.2	08	2560
Decedent's Name (First, Midd	die, Last)							2. Date of I		Day	Year	8:40 PM M
Lillian E. Ro Facility Name (If not institution		umher)		4b. City, T	own, or l	ocation of	Death	Augu			2008 ty of Deatl	
Washington Ad	-			4b. Oity, 1		Takor		ark			tgome	
ocial Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1		If Under 2 Hours			Birth Day, Ye		9. Birti	hplace (State or Foreig
579-28-3639	1 □ M 2 🖾 F	86	Yrs.	WOULTS	Days	Tiodis	191111.	05/			DC	
al Residence of Decedent State 10b. Count	v	10c. City	, Town or Lo	cation				-				10d. Inside City Limits
		TI a	koma E	o rle								1 XYes 2 ☐ No
Street and Number	tgomery	10	IKOMA I	10f. Zip (	Code				10g.	Citizen o	f What Co	untry?
007 Woodland	Ave.			20	912-				1	Unite	d St	ates
Marital Status		cedent Ever in U.S	S. 13.	Was Decede	ent of His	panic Orig	in? (Sp Puerto	ecify Yes or i Rican, etc.)	No-		ace - Ame	rican Indian, e. etc.
□ Never Married 2 □ Ma	arried 1 □Yes If Yes, G	2 🛣 No ∂ive		1 □Yes 2		Specify:				Spec	ihe	
3 ☑ Widowed 4 ☐ Divorce		Dates:	162 Dece	dant'e Heusl	l Occupat	tion	-		16	Kind of	Business/	nite
(Specify only high	ent's Education nest grade completed		(Give	dent's Usual <i>kind</i> of work DO NOT use	k done du e retired)	uring most	of work	ing		Medio		madou y
ementary/Secondary (0-12)	College	(1-4or 5+)		ses Ai								
Father's Name (First, Middle	e, Last)					18. Mother	r's Name	e (First, Midd	ile, Mai	den Surna	ame)	
Walter Harri	ngton					Eli	zabe	th Br	owni	ng		
. Informant's Name/Relation	nship (Type. Print)		19b. Mailir	ng Address	(Street ar	nd Numbe	r or Rur	al Route Nur	n <i>ber, C</i>	ity or Tow	m, State, Z	Zip Code)
Karin Andersor	n/Friend							akoma	_			
Method of Disposition 1 ☐ Burial 2 🖺 Cremation	n 3 ☐ Removal from	n State	lace of Dispo emetery, crer	sition (Nam matory or ot	ie of her place,	)	[	Date Aug 7				Town, State
4 □ Donation 5 □ Other (			hesape	ake C				2008		Belts	ville	, Maryland
shock, or heart failure. Lis nediate Cause (Final ease or condition	a	caused the death each line.	rator	933 Gi	ist A	ye.	Silv cardiac	or respirator	ing,	Mary	yland	Approximate Interval Between Onset and Death
shock, or heart failure. Lis mediate Cause (Final lease or condition sulting in death)  quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or injury to initiate events	a	Respu	rator uence of): valuence of): significant	933 Gi	ist A	ve.	Silv cardiac	er Spr or respirator	ing,	Mary	yland	Approximate Interval Between
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State

Registrar

08-05873 Charles Rogers

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	, g. c	eg. No	008 2560					
Physici		1. Decedent's Name (First, Middle,Last)	Date of Dea     Month	Day Yea	Time of Death					
/ledical Examinei ಓ		Charles Julius Rogers Jr.  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	August 1,	2008	0232 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Northwest Hospital Center Randallstown		4c. County o						
Funeral		Northwest Hospital Center Randallstown Baltimore County  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or								
Director		219-98-0693 1XM 2F 38 Yrs. Months Days Hours Min.		L3 <b>7</b> 0	Foreign Country) MD					
á:	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								
ow any		MD NA Baltimore			1 XYes 2 No					
Maryland 28a-f show 1 at once.		10e. Street and Number 10f. Zip Code		On Citizen of M/h						
th the Maryland 23a or 28a-f sho notified at once.		6704 Yataruba Drive 21207	[ ]	10g. Citizen of What Country?  U • S • A •						
ith th	alD	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	anif . Van av Na		14. Race - American Indian, Black,					
ath w items	ner	1 XNever Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		14. Race White						
her de	/ Fu	3 Widowed 4 Divorced If Yes 6 Sive Year 1 Yes 2 X No specify:		Specify:	Black					
hours al 'natural Examin	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w		16b. Kind of Bu	siness/Industry					
72 hc	leted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired	red)		4 6 4					
5-0036 led within 7 Hygiene. other than	ompl	12th grade na Auto Body Mechanic			tive Shops					
Filed Thyging the characters of the characters o	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name								
2121 vuld be fi Mental I marked		Charles J. Rogers Sr. Tawanna  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R								
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, Print )  Tawanna Rogers-Mother  19b. Mailing Address (Street and Number or R 6704 Yataruba Dri								
e, N and 2 fealth item 2 traur		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date		City or Town, State					
Baltimore, bermit Pages I ar Department of Hes Important: If itei		1 XBurial 2 Cremation 3 Removal from State crematory or other place)			·					
Itin		Donation 5 Other Specify: King Memorial Park 8/	14/08	Woodl	awn, Md					
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		I March F/H West								
Physician		23a. Part I. Erfur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	r respiratory arr	est, shock, or hea	art Approximate Interval					
/Medical		failure. Listionly one cause on each line.  Immediate Cause (Final disease a. Alcohol & narcotic (methadone) intoxication								
Examiner		or condition resulting in death)  Due to (or as a consequence of):								
	<u>.</u>	Sequentially list conditions,								
	je	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Undenlying cause C.								
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		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	nov.	23d. Date of Month						
Ox 68's ath certificate attending or use as	cia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	ricy	Month Day Year						
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Records, The law require	Completed			performed? death?  ✓ Yes 2 No 1 ✓ Yes 2 No						
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of Vital ng Physician After this certi	To B	1 ✓ Yes 2 No Pospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 4 Nursing	g Home 5	Residence 6	Other:					
n of ling Ph After funeral	Ë	(Month, Day, Year)	_	how injury occurre	ed					
Sior Mttend death ctor:	äį	2 Accident Pending Investigation Fnd 8/1/08 Fnd 2:10am Pending Investigation	unk							
Division pital or Attendi ours after death.	Certification:	3 Suicide 6 X Could not be determined (Specify)  Suicide 16 X Could not be determined (Specify)	28f. Location (	Street and Number $3101$	er or Rural Route Number, City					
lospita houri unera Iy fill		4 Homicide (Specify)  29a. Certifier								
Division of Vital Records, P.O. Box 68 within 24 hours after death certifulin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only only only only only only only only								
To To	Me	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signe	ed (Month, Day, Year)					
		O.C.M.E. 00	ME	August 1, 2	2008					
	ŀ	30. Name and address of person who completed cause of death (Item 23a)								
10	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature										
Regist		AUG 0 8 2008								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 and (First, Middle, Last) SAVOY, JR. 4b. City, Town, or Location of Death 4c. County of Death

Physician /Medical Examiner

1 - State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylann Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be morthled at once.

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Division of Vital Records,

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hour within 24 hour To the Funers completely fill the Edizian Medical Completely fill the Edizian Comple

1. Decedent's Name (First, Middle, Last) 8:22 P M JOHN E. SAVOY, JR. 4a. Facility Name (If not institution, give street and number) MANOR CARE OF LARGO PRINCE GEORGE'S UPPER MARLBORO 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 DC 7. Age (In vrs. last birthday) 1 🕅 M 2 🗆 F Months Days Hours JAN 9, 1943 577-58-9285 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 X Yes 2 ☐ No MD PRINCE GEORGE'S TEMPLE HILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 IISA 3206 CURTIS DRIVE #208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 □ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify. Specify: \$ 3 ☑ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GREETER WALMART 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN ELLSWORTH SAVOY, SR. HAZEL NEWMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3302 CURTIS DRIVE #101 TEMPLE HILLS, MD 20748 VENUS MURRAY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 0812-2008 CLINTON, MD 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 20746 SUITLAND, MD DONALD R. GRAY 4308 SUITLAND ROAD 23a. Parti. Enter the disease shock, or heart failure. L Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Acute Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Anemia Due to (or as a consequence of): Physician/Medical Thrombocytopenia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown <u> Polycythemia Vera</u> Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 🏹 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D0062116 AUGUST 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20770

GREENBELT, MD

MEKLIT WORKNEH 7
31. Date filed (Month, Day, Year)

AUG 0 8 2008

2. Registrar's Signature

ORIGINAL

7705 BELLE POINT DRIVE

08-05931

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erome Scott	1- For State	State o	of Maryland /			nd Mental I	Hygiene				
Physician	Registrar  1. Decedent's Name	Cenincale of Death					Re 2. Date of Deat	g. No. 2	108 Time o	2550 TDeath	
Medical Examine	7	me	Scott				Month August 3,		0046	hrs	
		f not institution, give : prial Hospital -	street and number)		4b. City, Town, Baltimore	or Location of Dea		4c. County of	Death ·		
Funeral Director	5. Social Security N	1252 1 X		(In yrs. last birthday)		ear If Under 24H ays Hours M			9 Birthplace (St Foreign Country)	ate or	
any	Usual Residence of 10a. State	Decedent 10b. County	11	0c. City, Town or Lo	cation		110-10	<u> </u>	10d Insid	le City Limits	
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the Maryland a or 28a-f show tifted at once.	10e. Street and Nur		41	·	10f. Zip Code	~	10	g. Citizen of Wha	t Country?		
ith the Maryland 23a or 28a-f sho notified at once		.22nd	Stree	et	21	218		U-	SA		
r death with or items 23	11. Marital Status 1 Never Marrie	(% A)	12. Was Decedent E Armed Forces?			Hispanic Origin? ( an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - White,	American Indian etc.	, Black, -	
15-0036  filed within 72 hours after death with the Maryland Hygiene.  co other than "natural", or items 23a or 28a-fate, the Medical Examiner must be notified at once Commission of the Medical Examiner of the concession of the Medical Examiner of the Commission of the Medical Examiner of the Commission of the Commis	3 Midowod	4 Divorced	1 Yes 2 FYes, Give Year or Dates:	No 1	Yes 2	No specify:		Specify:	Black		
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5-0036 ed within 72 hour hygiene. other than "matu	12	11ddiy (0-12)	O	C	istad	ian		Housin	na Aut	barity	
215-0036 be filed within 7 ntal Hygiene. Red other than ent, the Medical		First, Middle, Last)	. 1			18.Mother's Nar	ne (First, Middle, N	faiden Surname)	19 × 1111	entry	
212 Id, be Menta narket		me/Relationship (Typ	pe, Print) (nie	19b. Mai	ling Address (Str	eet and Number o	R al Route Num	ber, City or Town.	State Zin Code		
D sho and and a sho	INIS, Bre	inda Di	ickerso	$n \mid 30$	1E.22	nd St.	Baltz	Md.	2121	8	
ore, Mes land 2 of Health If item 2	20a. Method of Disp 1 X Burial 2		Removal from State	20b. Place of Disp crematory or	oosition (Name of other place)		Date / 2 / p	20c. Location - C	City or Town, Stat	e	
트리트를 늘		Other Specify:	20				13/2008	UWING	is Mil	Is, Md.	
Balti permit. Departn Import	COLON	) A	RIA	1/ 5	Name and Addre	L. Russ	funera	y Home	P.A.		
Physician	23a. Part I. Enter he failure. Listion	e disease, or complic y one cause on each	ations that caused the	ne death. Do not ente	er the mode of dyin	ig, such as cardiac	or respiratory arre	st, shock, or hear		mate Interval n Onset and	
/Medical caminer	Immediate Cause (F	Final disease a. H	ypertensive Ath		rdiovascular D	Disease				Death	
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	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause										
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recu		d	AMENDED		····						
760, cate be exphysician the burial	IF FEMALE:		23c. If yes, outcome	e of pregnancy				23d. Date of d	elivery		
Box 6876  e death certificate the attending phy ed for use as the laweing an IM.	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)							Month Day Year			
<b>1</b>	1 Yes 2 N	= 10 - 20	g Unknown		Other (Specify)						
			ontributing to death t	out not resulting in th	e underlying cause	e given in Part I.		2 No 3			
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ecor he law i te has l ge 2 sh							autops	ned? de	or to completion ath?		
					26.Pla	ce of Death (Chec	1 Yes 2 k only one)	NO I	Yes 2	No	
f Vital   Physician: or this certifical director,		2 No		2 V ER/Outpatie					Other:		
트를 고독리 참	1 Natural	5 Pending	28a. Date of Injury (Month, Day, Yea	28b. Time o	· ·   _	jury at Work? Yes 2 No	28d. Describe h	ow injury occurred	i		
	2 Accident 3 Suicide	Investigation  6 Could not be	28e Place of Injur	ry - At home, farm, st				treet and Number	or Rural Route N	lumber, City	
Spital hours a filled		determined	(Specify)				or Town, St			9.	
Division  To the Hospital or Attent within 24 hours aller death To the Funeral Director: completely filled in by the	(Check only 1 one)										
To To Com	29b. Signature and t	a	nd manner stated.	4		nse number		29d. Date signed		ear)	
		J N	VI. TE		0.0	C.M.E.	_	August 3, 20	800		
721		ess of person who cor			onn Ctro-: D	oltima = - 14D c	1201	···			
State	Jack Titus M 31. Date filed (Month	n, Day, Year)	nief Medical Exa		erin Street, Ba	altimore, MD 2	1201				
Registra	//	UG 0 8 200	8 Marie	c K A	all	<del> </del>					
DHMH 17 Rev 1/2001			*	ORIGIN	AL						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Thomas Jay Smith 1:10 PM Jul 29, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Randallstown Genesis Eldercare - Randallstown Center **Baltimore** If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 177-36-0594 Director PA 64 May 20, 1944 Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director **Ellicott City** MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must b 21042 U.S.A. 3222 Green Forest Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 Yes, Give 1 ☐ Yes 2 No þ White 3 Widowed 4 Divorced Year or Dates ed other than "natural", event, the Medical Exa Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Mere **Policy Analyst** Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Caroline Ruprecht John Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3222 Green Forest Ct. Ellicott City, MD 21042 Judy Hauswirth Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug 01, 2008 Glen Burnie, MD Atlantic Crematory, LLC 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No 2 Fetal death 3 ☐ Ectopic pregnancy jo Day 5 Other (specify) ed by the a detached f signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page death? 2□ No 1☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 100 2 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA A Wirsing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 4 hours after death. -uneral Director; A ely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Differentiation and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Hospital or Attending

death.

completely

within 2.

The law requires that the death certificate be executed

P.0.

Records,

Division or Vital

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

30. Name and address of persons

29b. Signature and title of certifier

(Check only

32. Registrar's Signature

expleted cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Marilyn Schwing 6, 8:30 AM 2008 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 F 290-18-8543 85 Yrs Director 5/21/1923 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits show the Medical Examiner must be notified at MD Baltimore Director 1 Yes 2 No items 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 1452 E. Baltimore St. U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 10 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked out any injury or other traumatic even any injury or other traumatic even l and 2 should be fill fealth and Mental F Laird Miller Isabel Ferguson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Schwing/Son 141 Pine St, East Aurora, NY, 14052 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 8/8/2008 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/ Stephen D. Lohrmann PA 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr., Towson, MD, 21286 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stroke maranha MONTA 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner infections months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Box 68760, Physician: The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOST LC Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the felety filled in by the funera 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier √C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 58303 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/200

MEN J. CHALIES

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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N. Cherles ST

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ANGUST

PUTSON MD ZIZOY

			Pleas  1 - For State Registrar	se Type or Pri	aryland / Depa		ealth and M	lental Hy	_		
	Physici /Medi	cal	1. Decedent's Name (First, Middle Charles Robe	rt Sapack				2. Date of De Month	Day 5, 2008	Year 3. Time of Death	
	Examir Funeral Director	ICI	170 22 0130	Hospice Cen		4b. City, Town, or TOWSON If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 10/5/1	Balti		
	Ba-f show	Director	Usual Residence of Decedent  10a. State 10b. County  MD N/A		10c. City, Town or Lo	`e			-	10d. Inside City Limits  1XXYes 2 □ No	
1	ms 23a or 2	Funeral Dire	10e. Street and Number 6517 Hilltop  11. Marital Status	12. Was Decedent	Ever in U.S. 13.	10f. Zip Code 21206  Was Decedent of Hir If Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No		SA - American Indian,	
-0036	72 hours after beath with the maryand inatural", or items 23a or 28a-f show ofcet Examition must be notified at	þ	1 ☐ Never Married 2 Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	Korean	1 ☐ Yes 2 ☑ No	Specify:		Specify:	White, etc. White	
2121	Hygiene.  Sther than "na ent, in the single.	Completed	(Specify only highes Elementary/Secondary (0-12)  17. Father's Name (First, Middle, 1	College (1-4or	(Give	kind of work done done done do NOT use retired) duce Manag	uring most of worki     <b>er</b>			ocery	
larylan	s I and z should be of Health and Mental Item 27 Is marked other traumatic even	To Be	Andrew Sapack	nip (Type. Print)		ng Address (Street a	Anna I	Miketa al Route Numb	State, Zip Code)		
re, N			Ms. Dawn Esposi  20a. Method of Disposition  1	3 Removal from State	20b. Place of Dispo	26 Apperson Solution (Name of matory or other place) Lev Mem Gam	e) [	Date	e, MD 21  20c. Location - C  Timonium	City or Town, State	
Baltin	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	icensee	2	2. Name and Addres	s of Facility	, Inc.	5305 Ha Baltimo	rford Rd. re, MD 21214	
E	hysician /Medical xaminer	ner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, each grade to the cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury)	a	a consequence of):	ter the mode of dying		or respiratory a	rrest,	Approximate Interval Between Onset and Death	
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	been signed I should be det	Completed by P	Part II. Oth sir lifeant condition			inderlying cause give	en in Part I.	1 🗆	Yes 2□No	bute to the cause of death?  3 Probably 4 Unknown	
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Division of	After this funeral dir	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin investig  3 Suicide 6 Could r  4 Homicide determ	28a. Date of Inj (Month, Date of Inj not be 28e. Place of In	ent 2 ER/Outpatie ury ay, Year) 28b. Time of Injury jury - At home, farm, st	of 28c. Injury Work M 1 🗆	er: 4 Nursing Ho vat er ves 2 No	Home 5 ☐ Residence 6 🛣 Other (Specify) HOSPICE  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	within 24 hours after death  To the Funeral Director:  completely filled in by the	edical Co		g Physician: To the best Examiner: On the basis and manner s	of examination and/or in			red at the time,	date and place, a	nd due to the cause(s)	
	withi Com	M	29b. Signature and little of certified	do de to	745)		number	7	29d. Date signed	(Month, Day, Year)	
	Sta Regist		DR. EDDIE NAKH  31. Date filed (Month, Day, Year)	UDA 2300 DI	JLANEY VALI rar's Signature		IMONIUM,	MD 210	93		

1036	Purs after death with the Maryland Medical, or items 23a or 28a-1 show Examine the principle of the principl	To Be Completed by Emparal Director
altimore, Maryland 21215-0036	mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene. Sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show I riqury or other traumatic event, the Medical Evanting rough by notified at the Example of the CE.	To Be Complete

			1 - State Registrar		Cer	tificate of	Death			Reg. No	2000	25610
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	/Medic		Marvel, C	Stephenson					JULY	3	1 2008	
	Examin	er	4a. Facility Name (If not institution, giv	street and number)		4b. City, Town, o			_	4c.	County of Death	
, , ,						If Under 1 Year	BALI	MOR			I/A	nines (State or Couries
	Funeral Director			ex 7. Age (In yrs. las	Yrs.	Months Days	Hours	Min.	3. Date of B (Month, D			place (State or Foreign ntry) Land
and	<b>*</b> #		10a. State 10b. County	10c. City,	Town or Loc	cation						10d. Inside City Limits
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deat	Sms	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of F f Yes, specify Cub	lispanic Ori	igin? (Spec	ify Yes or N	0-	14. Race - Ameri Black, White,	
OCOO nours after	al", or ite	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		Yes 2/1/No	Specify:	i, rueno n	ican, etc.,		Specify: Whi	
<b>5</b> 25	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: if them 271 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and once.	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	lent's Usual Occup	oation	t of working	7	16b. K	ind of Business/Ir	ndustry
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d 2			Joan Stephenson		2980	Cornwall	Road			212	222	
Ore			20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐	Removal from State	ce of Dispos netery, crem	sition (Name of natory or other plac	ce)	Da	te	20c. L	ocation - City or T	own, State
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Dallillo permit. Pages	Depar Impor any In		21. Signature of Funeral Service Licer	See 2		. Name and Addre						e of Dundalk 1 21222
	nysician	s 15	23a. Fart 1. Enter the disease, or om shock, or heart failure. Let only immediate Cause (Final disease or condition	plications that caused the death. one cause on each line.  ACUTE		er the mode of dying			respiratory	arrest,		Approximate Interval Between Onset and Death
	Medical kaminer		resulting in death)	Due to (or as a consequen								
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tificat	g phy as the	Medical										
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aw C	as be 2 sh	Completed	GRANIS, CHRONI	E RENAL FAILUR	LE, 51	KK 5120	<b>S</b>		24a. Wa	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
The	ate h		SYNDROME ST	ATUS POST PACEMAN	ceR				per 1 □Yes	formed?	death? 1 □ Yes	2 □ No
ian:	ertific ctor,	Be (	25. Was case referred to medical examiner?				26. Place	of Death	(Check only			
hysik	his c I dire	흔	1 Yes 2 No	Hospital: 1 XInpatient 2 ☐ Ef	R/Outpatien	t 3 □ DOA Oth	ner: 4□ Nu	ursing Hom	e 5□Re	sidence	6 ☐ Other (Spec	ify)
ng P	ofter t	ü.	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	8b. Time of Injury	28c. Inju Wor	ry at 'k?	28	3d. Describe	how inju	ry occurred	
VISIO(I) OI Attending Phy	or: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b				Yes 2□					
or At	ifter d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	eet, factory, office		28	3f. Location City or To	(Street al own, State	nd Number or Ru e)	ral Route Number,
ospital	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 12 Certifying Pl	nysician: To the best of my knowledge:  On the basis of examination	ledge, death	occurred at the ti	ime, date a	nd place, a	nd due to th	e cause(s	s) and manner as	stated.
he H	nin 24 the Fu	Medical	one)	and manner stated.	and/or in			au occurre	u at the time			
5	To 1	Σ	29b. Signature and title of certifier	2 MO		29c. Licens		_			ate signed (Month	
			· (in			KES	-00	<i>-</i>		Jul	LY 31,2	100B
	( )		30. Name and address of person who	completed cause of death (Item 2	23a) (Type, F	Print) 40 EAST	FRIN	AVE	NUF	RA	I TI MARE	MD 21224
	Ψ		CHRISTOPHER H 31. Date filed (Month, Day, Year)	32 Registrar's Signatur		70 001	Civi	71101	14010	ON	CHAMORE	110 2122
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ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 8:38a M 08 06 2008 Shibu Nafisa /Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Joseph Richey Hospice 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2√□ F 45 Director 10 63 Ghana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; If a Modical Examination in the restriction and once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Baltimore NA MD 1 X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 Ghana 5536 Channing Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married & Married Maryland 21215-0036 1 ∐ Yes 2 ∐**X**lo Specify \$ Specify. Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Geriatric Nurse 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Amina Musa Mohammed Paaty ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Amy Brent Way, Reisterstown, Md 21136 Rashid Ibrahim-Cousin Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 8/7/08 Woodlawn , Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West hom psur 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death UNKNOWN 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician End /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit Due to (or as a consequence of): 68760, attending physician for use as the buria Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) o detached 9 Unknown 9 Unknown σ. cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 □ Yes 2 □ No Vital Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Mether (Specify) Mask 1∐ Yes 2☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ot this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) www, mo

State Registrar

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Hanover Sh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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**Physician** 

/Medical

Examiner

Funeral

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The law requires that the death certificate be executed

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 15:17 PM Margaret Seidewitz Aug 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL OF BALTIMORE BALTIMERE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, June 2, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months 1 □ M 2 🖾 F 1918 Maryland 90 218-03-3872 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Lutherville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 516 Brightfield Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: white Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) office clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louie H. Davis Vivian V. Wilhide 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sams/daughter 11825 Garrison Forest Road Owings Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Servi 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street ans Baltimore, MD 21201 23a. Part1 Enter the disea shoc or heart failurs. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Li Immediate Cause (Final disease or condition resulting in death) HEMORRHAGIC ALCODENT EREBROVAS CULLAR Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 MER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D53377 3,2008 M. A 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) AVE. BALTIMORE , MA 2 2401 W. BELVEDERE Au MAHAJABIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dav Year vedev 1608 ZUES /Medical 4a. Facility Name (If not institution 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Homova 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 □ F March 8, Yrs. -256 Director Washington Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director more 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ 3 Widowed 4 Divorced Blace Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If them 27 is marked other tham any injury or other trainment. orKer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0 ပ 19a. Informant's Name/Relationship (Type. Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 12008 9 4 Donation 5 Dother (Specify) meteri Ce 22. Name and Address of Fability
Joseph L. Russ Funeral Home, P
2222 W. North Ave. Buito. Ma. 21. Signature of Funeral Service Licensee 23a. Part Effet the crease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shield, or heart fillure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** iuseu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any total group to in modals cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Daw to for as a consequence off requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending property for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) P.0. p signed to significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 should t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 1 ☐ No 24a. Was an page 2 s autopsy performed certificate 2/2/No 1∐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) SONO 2 1 Tes 1 Inpatient ≥ ER/Outpatient 3 DOA this After th funeral 27. Manner of Death

1 Natural

2 □ Accident To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No → 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. 'Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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ate 31. Date filed (Month, Day, Year)

30. Name

30 St. Vau

and address of person who completed cause of death (item 23a) (Type, Print)

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Baltimore

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 08 06 2008 Eileen C. Taormino 08:25a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Good Samaritan Nursing Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 01/15/1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Months 1 M 2 X F Mary Land 220-22-4178 80 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show er than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at Director 1 X Yes 2 No MD Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21206 4002 Parkwood Avenue U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐Yes 2 X No altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No þ Specify 3 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Leonard Callahan, Sr. Marian M. Whalen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oscar J. Taormino, Sr., Husband 4002 Parkwood Avenue, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of
Important: If It
any Injury or o 1 ☐ Buriał 2 XX Cremation 3 ☐ Removal from State Hilltop Svc. Corp. 08/09/08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Depondia 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of burial-transit Exam and the death certificate be exec Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a detached for 1 ☐ Yes 2 Wo 9 Unknown 9 I Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, SIP per-forated duodenal ulcer with peritoritis, dialetes, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nhknown urinary tract infection, it breast 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performed? Yes 200No cancer 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 1 No Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation **1** ■ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide **TEX** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) completed cause of death (Item 23a) (Type, Print) BIVA

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State of Maryland / Department of Health and Mental Hygiene

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ancy Webb		State of Maryland / Department of Health and Men For State  Certificate of Death	nai nygiene Reg. N	2000 2001
hysician		egistrar . Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
Me . Examine		Nanc'y Webb  La Eacility Name (if not institution give street and number)  4b. City, Town, or Location	Month Da August 3, 200	1020 Til S 4c. County of Death
		Ia. Facility Name (if ∮ot institution, give street and number)  501 East Preston Street, Apartment 304  4b. City, Town, or Location  Baltimore		NA
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Months Days Hour		M/DD/YYYY) 9. Birthplace (State or Foreign
Director	2	219-62-4428 1 M 2XF 54 Yrs.	June 23	2,1954 Country) Virginia
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
and f show	اة	NId. N/A Baltimore	1100	1 Yes 2 No Citizen of What Country?
Maryl r 28a-	Director	10e. Street and Number (10f. Zip Code )	log.	// < A
		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or	igin? ( Specify Yes or No-	14. Race - American Indian, Black, White, etc.
death or item	Funeral	1 X Never Married 2 Married Armed Forces?  1 Yes 2 X No		Dist
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O # B * #	ᆰ	19a. Informant's Name/Relationship (Type, Print) (Brother) 19b. Mailing Address (Street and Nu	mber or Rural Route Number	r, City or Town, State, Zip Code)
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altimore, mit. Pages I a spartment of He portant: If its	1	1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify:	8/7/2008	Pikesville, Md.
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	4	222 V. Nort	h Ana. Bal	, shock, or heart Approximate Interval
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Examiner		or condition resulting in death)  Due to (or as a consequence of):		
	ē	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):		
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60, tie be executed hysician and e burial - transit	ledical	X UNPENDED		23d. Date of delivery
Box 68760, e death certificate be the attending physic reference as the burner of for use as the burner of for use as the burner of for use as the burner of	W/UE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ecto	pic pregnancy	Month Day Year
ox 6 sath cer attendi	sician/N	1 Yes 2 ✓ No 9 Unknown 9 Unknown 9 Unknown		
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and luneral director, page 2 should be detached for use as the burial - trans	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		acco use contribute to the cause of death?
s, P.	ed by		1 Yes	2 No 3 Probably 4 Unknown  1 24b, Were autopsy findings available
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Rec The la ficate h	Com	26 Plane of Dea	1 ✓ Yes 2 ith (Check only one)	No 1 Yes 2 No
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be deach	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4		esidence 6 🗸 Other: Scene
of \ ng Phy After th		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at W		ow injury occurred
Sion Vitendi death. setor:	catio	1 X Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building		reet and Number or Rural Route Number, City
Divis tal or A rs after al Dire	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, Sta	
Hospi 4 hou Funer ely fil	a C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and	place, and due to the cause	(s) and manner as stated.
To the To the complet	Medical	(Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death and manner stated.  29b. Signature and title of certifier 29c. License number 20c.		29d. Date signed (Month, Day, Year)
	2	O.C.M.E.		August 4, 2008
		30. Name and address of person who completed cause of death (Item 23a)		
		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Balti	imore, MD 21201	
St Regist	ate trar	rest of the second of the seco		
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APRIL 1119#9 perfil 082.8808.W
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 **Physician** Month Maomi /Medical lity Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year Birthplace (State or Foreign Country) I If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Days Hours Min. Months 220-22-3226 Yrs Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Mardical Everminer must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director toro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 8/3/08 1244 FM Baltimbre, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ifir, Md East King Factory 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cardons of Faith Cemetery 8/4/08 ROSEdale Md 2. Name and Address of Facility Evens Fund Chapter + Cremtion 21. Sign ture of Functial Service Licen ee 3 Newport Drive Forest Hill, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ante responde /Medical Due to (or as a consequence of): Examiner ardione Due to or as a consequence of Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner burial-transit and Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy rmed? 2 □ No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: al or Attending Physis s after death. Il Director: After this o 2 No ပ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 32239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6,5 ショット Marcha J Rd. Bel Air, MD 2 20, O, una Co 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 0 8 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	ryland		artmen <i>rtificat</i> e			d Me	-	gien Reg. No	0.0	<b>1</b> 8	256	. LB
	Physici	an	1. Decedent's Name (Fin		)						2.	Date of De Month	Da		ear_	3. Time of De	eath
-	/Medic	cal	Rosie Lee Wh		street and number)			4h City	Town or	Location of D	eath	ugu	-	5. County of	208	12:30	/ M IVI
,	Examir	ier	Doctors Camun						ham	Location of D	odiii			Prince		rges	
	Funeral Director	Γ	5. Social Security Number 412-64-9182	1[	x 7. Age	(In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours N	Hrs. 8. Vin.	Date of Bir (Month, Da 4-6-192	th y Year			ace (State or F	Foreign
	land ow		Usual Residence of Dec 10a. State 10b	edent . County		10c. City,	Town or Lo	cation					-		10	d. Inside City	Limits
	death with the Maryland ms 23a or 28a-f show Frount to 15 (if of all	to	MD :	Prince Ge	orce	Ta	nham									1 □Yes 2	√ No
	h the	irec	10e. Street and Number		-280			10f. Zip	Code				10g. C	itizen of Wh	at Count	ry?	-
	23a c	ral	8703 Nightin	gale Driv	e	20706						US	Ä				
2036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exportment must be reaffiled at ODGs.	d by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 ∐Yes 2 ZNNo If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 X No Specify:			y Yes or No an, etc.)	or No- c.) 14. Race - Americar Black, White, etc SpecifAFrican		tc.	an '		
5-6	72 h "natu	ete	15. (Specify of	Decedent's Edu nly highest grad	cation e completed)		16a. Deced (Give	ient's Usua kind of wor	l Occupa k done d	ation Juring most of	working		16b. ł	Kind of Busin	ness/ind	ustry	
212	d within giene. er than	Completed	Elementary/Secondary 8 <b>th</b>	y (0-12)	College (1-4or 5+	)	Homema		nd of work done during most of working ONOT use retired)  RET  Damestic						2		
Rasie $\lambda$ ee Maryland 21215-0036	d be file ental Hy ked othe c event	To Be (	17. Father's Name (First, Middle, Last)  Bill Gilliam  18. Mother's Name (First, Middle, Maiden Surname)  Pearl Bass														
ary S	2 shoul and Ma Is mark aumath	F	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State									ate, Zip	Code)				
	and 2 ealth n 27 I		Evon White/Dan							Drive, I	anhan	n, MD 20					
te	ges 1 nt of H if itel		20a. Method of Dispositi 1 ☐ Burial 2 ☐ Cre	emation 3 🗆 F	Removal from State	1	ce of Dispon netery, cren		ne of ther place		Date			ocation - Ci	•		
Why le Baltimore,	artmer artmer ortant: injury		4 □ Donation 5 □ 21. Signature of Funeral			Metr	o Crema		d Addres		6-08 wita	Hi mere		ltimore		yland Balto. C	<u> </u>
2 g	permir Depar Impor any ir	(	Mana	(CV)	4. Cely,	110				Road, Ra						zito. G	J.
	Physician /Medical		Immediate Cause (Fina disease or condition	Due to (or as a consequence of):												Approximate Interval Betwe Onset and Dea	en ath
	Examiner	iner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury)	le	ed Sacral & Cubit												
68760, <	icate be executed physician and s the burial-transit	ledical Examiner	that initiated events resulting in death) Last	a consequence of): 1  7 c Shock									-+:				
O. Box	ath certif uttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 No   9   Unknown   1   Unknown   2   Tetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   1   Unknow										23d. Date of Month		y Day Yea	ar	
rds, P.	quires that the de an signed by the a uld be detached f	þ	Part il. Other significant	t conditions cor	ntributing to death but	not resulti	ng in the ur	nderlying ca	use give	n in Part I.			obecco Yes 2		_	e cause of dea	
Division of Vital Records,	Physician: The law requir this certificate has been s ral director, page 2 should	Completed								-	-	24a. Was autop perfo 1 □ Yes	rmed?	prio dea	re autop or to com oth? Yes	sy findings ava pletion of caus	ailable se of
/ita	lcian; sertific ector,	Be (	25. Was case referred to examiner?	H	Inonital.				Lau	26. Place of	Death (C	heck only o	ne)				
of	<u>~ .⊎ ~</u>	٦.	1 ☐ Yes 2 No 27. Manner of Death		1 Inpatien 28a. Date of Injury		R/Outpatien 8b. Time of			4 LI Nursir				6 ☐ Other	(Specify	)	
on	th. : After	tion		Pending investigation	(Month, Day,	Year)	Injury	M	Bc. Injury Work' 1 □ Y	es 2 □ No	200	. Describe r	iow iriju	ry occurred			
Divisi	al or Attending Ph s after death. Il Director: After th id in by the funeral	Certification:		Could not be determined	28e. Place of Injur building, etc.	y - At hom (Specify)	e, farm, stre	eet, factory,	office		28f.	Location (S City or Tox	Street a vn, Stat	nd Number e)	or Rural	Route Numbe	r,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical (	29a. Certifier (Check only one)	Certifying Phys Medical Exemi	sician: To the best of ner: On the basis of a and manner state	examinatio	edge, death in and/or inv	occurred estigation,	at the tim in my op	ne, date and p pinion, death o	lace, and	I due to the at the time,	cause(s	s) and manr ad place, and	ner as st d due to	ated. the cause(s)	
_	To the within 2 To the complet	ž	29b. Signature and title of	of certifier	2 1	1			License				29d. Da	ate signed (i	Month, E	ay, Year)	
			1	Mdi	werlub	-				2500			Au	gust	05	, 2008	\$
	/		30. Name and address of		empleted cause of dea	ath (Item 2	3a) (Type, F		118	Good			box				
	Sto	to	FOZIA T.  31. Date filed (Month, Date filed)		-WAHABE	's Signatur	9.	- 10	-anh	ian) h	UD	2070	6				
	State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature																

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Aug 3, 2008 6:30 PM Charlotte Isabella Young /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia **Lorien Nursing Home** If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 M 2 F 88 Aug 22, 1919 Director 227-20-7213 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 □Yes 2 No Columbia Funeral Director Howard MD 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 21044 U.S.A. 6336 Cedar Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare **Practical Nurse** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Love Gilliam William Roper Young ၉ permit. Pages 1 and 2 sh.
Department of Health and Important: If Item 27 is maany injury or are 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4102 Lotus Circle Ellicott City, MD 21043 Charles Dodd 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State Aug 05, 2008 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) Atlantic Crematory, LLC 21. Signature of Funeral Se 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner use as the burial-tran IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specity) cate has been signed by the a page 2 should be detached 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 2 No 1 Tes 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No On Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Tes 1 Inpatient Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and little of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Codarlane Columbia Mp

32. Registrar's Signature

**ÖRIGINAL** 

Registrar

B1. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>008</u> **Physician** Month Leanne Young August 4, /Medical 10:15 A M 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8508 Woodhaven Blvd. Bethesua

If Under 1 Year | If Under 24 Hrs.

Hours | Min. Bethesda Montgomery 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 1 □ M 2 5 d F Year 113-24-2749 Director Yrs. 77 1931 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8508 Woodhaven Blvd. Funeral 20817 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ulrich Miron Hutchinson ည Lola Josephine Hessel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank E. Young/Husband 8508 Woodhaven Blvd., Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2008 Bethesda, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M00896 23a. Part1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hill fee. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Melanoma disease or condition resulting in death) months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ∐ Yes 2 🔀 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier (Check only one) To the I within 2 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) 00067258 August 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas J. Farrell, M.D., 9707 Medical Center Dr., #300, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 330 PM Physician Year Elizabeth Zappa 4th 2008 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harfor Bel Air Health and Rehabilitation Bei 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Day, Dec 30, 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 212-03-6609 MD) 91 Dec Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits MD Harford Fallston 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2212 Queensbury Drive 21047 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo White Specify Specify. 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Associate Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Wills Barbara Bergman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Bill Zappa (son) 2212 Queensbury Drive, Fallston, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 08/06/08 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Schimunek Road Bel Funeral Air, MD Home 21014 610 W. MacPhail 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical s a consequence of): Examiner Scumificity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 □Unknown has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one)

LIZABETH Vo the mosping within 24 hours after death.

To the Funeral Director. After this removately filled in by the funeral di

> State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1716 Harford Road, Suite 105 FALLSTON, MD 31. Date filed (Month, Day, Year) 32, Registrar's Signature

29b. Signature and title of certifier

		State of Maryland / Depa	rtment of Health and tificate of Death		211112	25622
		Registrar  1. Decedent's Name (First, Middle, Last)	lineate of Death	Reg. N		3. Time of Death
Physici /Medi		Paul Hexander Zinch	rook	08 02	2008	4:27PM
Examir	ner	4a. Facility Name (If not institution, give street and number)  Evant In Saura Hogo Fall	4b. City, Town, or Location of Deat	h 4	c. County of Death	and a
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign intry)
Director		Usual Residence of Decedent		2-22-4	18	MD
tryland show	_	10a. State 10b. County 10c. City, Town or Loc	eation			10d. Inside City Limits
the Ma 28a-f	recto	Maryland Baltimore	10f. Zip Code	Essex	Citizen of What Cou	1 ☐ Yes 2 🛣 No
ite, Infallylation ZIZIO-0000 stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Item Midcal Event with item 23.	Funeral Director	1707 Glen Curtis Road	2122	_	United :	•
er deat items	uner	Armed Forces?	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White,	
urs aft	Ď	1□Never Married 2河Married   太気Yes 2□No If Yes, Give 3□Widowed 4□Divorced   Year or Dates: Vietnam   1	☐Yes 2 No Specify:		Specify:	White
"natur	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of wor NOT use retired)	deina .	Kind of Business/Ir	
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d file intal Hy ed othe	Be	17. Father's Name (First, Middle, Last)		me <i>(First, Middle, Maide</i> nie M. Icen	_ *	
should nd Mer marke imatic	ဥ	Paul Zinchook  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing	g Address (Street and Number or Ri			ip Code)
y, IVIC and 2 seaith a n 27 is er trau			7 Glen Curtis Ro		Maryland	21221
Pages 1 nent of Hi		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, crem	sition (Name of atory or other place)	Date 20c.	Location - City or T	own, State
- + # # = -		21. Signature / Funeral Service Licensee 22.	Forest V.A. Cem.  Name and Address of Facility			Mills, MD
Depari Impor			uda-Ruck Funeral 1922 Wise Ave. D		dalk, Ind ryland 21	222
	g g	23a. Part 1. Enter the disease or complications that caused the death. Do not ente shock, or he failure. List only one cause on each line. Immediate Carse (Final	er the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  Due to or as a consequent to or:	each wraig	<u>.                                    </u>		
Examiner	Ļ	Sequentially list conditions, b. Myruc This	worker way d	iseace_		
uted d ansit	Examiner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that situations are only in the conditions of th	Ų			
cate be executed physician and the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):				
ficate be expression to the purial street burials	edical	d				
th certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the post 13 provide3  1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of deli	*
he dea the at	ysicia		Other (specify)		Month	Day Year
S, T. ss that t gned by se detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
require een sig				1 Des	2 □ No 3 □ Pro	obably 4 🗌 Unknown
ne law e has b ge 2 st	Completed			24a. Was an autopsy performed?	prior to c	opsy findings available ompletion of cause of
ILAI ian: Ti rtificate tor, pa	a l	25. Was case referred to medical	26. Place of De	1 ☐ Yes 2 ☑ 1 ath (Check only one)		2 □ No
Physic This ce	To B	examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpatient 2 ☑ ER/Outpatient		lome 5 Residence		sify)
ding lath.	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how in	ury occurred	
r Atter ter dea ter dea irector	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,
spital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place	e and due to the cause	e(s) and manner as	stated
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or invane and manner stated.	vestigation, in my opinion, death occ	urred at the time, date a	ind place, and due	to the cause(s)
To t With To t	Σ	29b. Signature and tipe of desirier	29c. License number	29d. [	Date signed (Month	, Day, Year)
1XA		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)	6 ~	4 1 .	
, C.		KAPARI PENEZ-MENA 400	DIOGES Print) EASTERN BY	VA - Essey	orud 2	124
Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG - 8 2008				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22 Day July **Physician** 2008 Hillary Anderson 11:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov. 28 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F 84 Yrs. 215-16-0041 Director 1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f sho the Medical Examinar is ust be notified at ¶Yes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 11 Bunche St. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Affred Forces:
1 Mayes 2 □ No
If Yes, Give
Year or Dates: 1943-46 1 ☐ Yes 2 ☐ Wo Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. United States Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any liqury or other traumatic event, the Once. 3rd Electrician Assistant Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paris Anderson Isabell Kyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy B. Anderson(Wife) Md. 21401 11 Bunche St. Annapolis, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 7-30-08 Cromsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Takmame Registers of Each Sons Mortuary, 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NUM C disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) physician Physician/Medical the i attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 □Yes 2 □ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy perform this certificate 2 DNO 1 ☐Yes 2 ☐ No 1 Tyes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes ours after death.

Neral Director: A
filled in by the fu death. 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di

State Registrar

DHMH 17 Rev 1/2001

completely

29a, Certifier

29b. Signature and title of certifier

Medical

within 72 hours after

law requires that the death certificate be executed

The

or Attending Physician:

Box 68760,

P.O.

Division of Vital Records,

3altimore, Maryland 21215-0036

and manner stated

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 **Physician** Eldon Elmer Batterton /Medical 4a. Şeçility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner IVISTA EDICAL ENTER Under 1 Year If Under 24 Hrs. 8. Date of Birth
Online Days Hours Min. (Month, Day, Social Security Number Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Year) 348-01-7535 97 **Director** October 8, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Experient must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9705 Faith Baptist Church Road 20695 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ∆Yes 2 □ No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Yes. Give Specify. white Completed by Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Auto Parts Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Washington Batterton Anetta Ford ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Batterton/Son Faith Baptist Church Rd. White Plains, MD 20695 Important: If Item any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 7/31/2008 4 Donation 5 Dother (Specify) Clinton, Maryland permit. Plun al Service Licengee 21. Signatur 22. AREHART ECHOLS FUNERAL HOME, P.A. M01458 211 St. Mary's Ave. La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** Intracranial henorchis /Medical resulting in death) Due to (or as a consequence of): Examiner entensia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a conse wence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Por Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? in by the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No 2 K ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

ATTERTON

La Grange Ave Po Box 2665 La Plata Md. 20646

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

lenkins

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31. Date filed (Month, Day, Year)

JUL 2

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32. Re

ML

strar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year Joseph Harold Butler, Sr. 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ATE/VI. Birthplace (State or Foreign Country) PA Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Sex 14∆M 2□F Months Days Hours Min. 217-42-8736 66 10,1942 pril Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 10h. County 1 ☐ Yes 2 No MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8822 Penns Hill Road 20646 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Equipment Tech State Highway Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Earl Butler Mary Hicks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Butler/Wife 8822 Penns Hill Road, La Plata, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation St. Mary's Newport 7/31/08 Charlotte Hall,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature peral Service License 22. AREHART-ECHOLS FUNERAL HOME, P.A. M01458 211 St. Mary's Ave. La Plata, MD 20646 23a. Part 1. Enter the disease, or camplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Year Day to the cause of death? Probably 4 | Unknown utopov findingo ovojloblo

Physician /Medical Examiner

requires that the death certificate be executed

attending p for use as t

been signed by the should be detached

page certificate

leted by

Box 68760,

P.0.

Division of Vital Records,

or Attending Physician:

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

Department of Health a Important; if item 27 is any injury or other trau once.

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

ပ

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be rictified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-tran physician s the burial-

in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		pic pregnancy r ( <i>specify</i> )		Month
Part II. Other significant condition	s contributing to death but not resulting in t	the underlyi		23e. Did tobacco u	use contribute t
- RENAL	FAILURE (	DN	DIALYSIS)	1 □ Yes 2	<b>X</b> No 3□ F
- DIABE	TES - TYPE	2		24a. Was an autopsy	24b. Were a
	TENSION			performed?	death?
25. Was case reerred to medical examiner?			26. Place of Death (	Check only one)	
4 Tives	Hospital:	_	Other:		

	- HYPER	ENSION	autopsy performed? death?  1 \[ \superset{Yes} \] 2 \[ \superset{No} \] 1 \[ \superset{Yes} \] 2 \[ \superset{No} \] 1 \[ \superset{Yes} \] 2 \[ \superset{No} \] No				
e e	25. Was case r erred to medical examiner?	26. Place of Deal	th (Check only one)				
2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	ome 5 ☐ Residence 6 ☐ Other (Specify)				
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work?	28d. Describe how injury occurred				
Cermic	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
2	29a. Certifier Certifying F	, and due to the cause(s) and manner as stated.					

(Chec

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

000 29b. Signature and title of certifier

26064

07-2-6-2008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIDYASAGAK AVDLA.

10583-THEODORE GREEN WHITE PLAINS, MD-

State Registrar 31. Date filed (Month, Day, Year)

32. Raistrar's Signature

		_	1 - State Registrar		Certificate of Death				Reg. No. 2008 25526				
	Physici	an	1. Decedent's Name (First, Middle JEANINE CRYST							2. Date of De- Month 2		8 Year	3. Time of Death 15:34 M
	/Medic	1	4a. Facility Name (If not institution				4h City Tow	n or Loc	ation of Deatl			nty of Death	13.34
1	Examin	er	SOUTHERN MARYLA	-			CLIN		ation of Deat			NCE GE	ORCES
	Funeral	2	5. Social Security Number		e (In yrs. la	ast birthday)	If Under 1 Ye	ear If	Under 24 Hrs.	8. Date of Birt	h	9. Birthpl	ace (State or Foreign
Zin.	Director		148-70-1143 Usual Residence of Decedent	1 □ M 2 🕏 F	45	Yrs.	Months Da	iys H	ours Min.	OCT 9,	1962	Count	JERSEY
	yiand iow at		10a. State 10b. County		10c. City	, Town or Lo	cation					10	Od. Inside City Limits
	a-f sh	tor	MD CHAR	RLES	WALI	OORF							1 XYes 2 No
	or 28,	Director	10e. Street and Number				10f. Zip Cod	de			10g. Citizen o	of What Coun	try?
	23a ust b		6018-3 NEW FOR	REST COURT			206	503			UNITI	ED STAT	TES
	tems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces? ied 1 ☐ Yes 2 🔥 N	Ever in U.S	6. 13.	Was Decedent If Yes, specify	of Hispa Cuban, M	nic Origin? (S lexican, Puer	specify Yes or No to Rican, etc.)	. 14. R	lace - America llack, White, e	
21215-0036	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by	1 □ Never Married 2 1 Married 3 □ Widowed 4 □ Divorced	ied 1 ☐ Yes 2 🔼 N If Yes, Give Year or Dates:	No		1⊡Yes 2 <b>X</b>	No S	pecify:		Spe	cify: BL	ACK
5-0	72 h "natu di al	etec	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Dece (Give	dent's Usual Oo kind of work do DO NOT use re	cupation one durin	n ng most of wo	rking	16b. Kind of	Business/Ind	ustry
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	iiie.	HOUSEV				PI	RIVATE	
d 2	art,		17. Father's Name (First, Middle,	Last)			пооры		Mother's Nar	me (First, Middle,			
Maryland	<b>6 9 9 9</b>	To Be	MELVIN LUCAS GA	DDY				J	DYCE AF	RTIS GAD	DY	,	
ary	2 should and Men is marker aumatic	-	19a. Informant's Name/Relations			19b. Maili	ng Address (St			ural Route Numb		vn, State, Zip	Code)
	다 하 를 다		RONALD J. BURKE	ES		6018-	3 NEW I	ORES	ST COUR	RT, WALD	ORF, MA	20603	
altimore,	0 0 <del>-</del> -		20a. Method of Disposition  1	3 □ Removal from State	20b. PI	ace of Dispo emetery, cre	osition (Name o matory or other	f place)		Date	20c. Locatio	n - City or To	wn, State
Ĕ	Pages ment of I		4 Donation 5 ☐ Other (S	(pecify)			MEMOR]	[AL	8/1/	/2008	ARNEY	TOWN, 1	UJ
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service	HOME, P.		EVID WI	20640						
r.			23a. Part1. Enter the disease, or shock, or heart failure. List	-			ter the mode of	dying, si	uch as cardia	c or respiratory a	rrest,		Approximate
9	Physician		Immediate Cause (Final disease or condition	Dall	Es.	eler	elic (	in	alay 1	VASCUL	Eas De	Seas	Onset and Death
J.	/Medical		resulting in death)	Due to (or as	consequ	ence of):	me	11	1.1				
Ю	Examiner		Sequentially list conditions.	b	) Let	uls	me	ll	ils			X.	nknown
	ted sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence of):							
	eath certificate be executed attending physician and for use as the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):						-	
68760,	burian												
687	ficate p phys s the	Medical		0									
×		-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnai						23d. I	Date of delive	ry
. Bo	death d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			⊒Ectopic pregn ⊒ Other <i>(sp</i> ec <i>if</i>						Day Year
P.0	The law requires that the death c tre has been signed by the attend lage 2 should be detached for us	Physician	9 ☐ Unknown	9□Unknown									
	gned gned	by P	Part II. Other significant condition	. // /	ut not resu	lting in the u	nderlying cause	given ir	Part I.	23e. Did t	obacco use co	ontribute to th	e cause of death?
or Vital Records,	w require been sig should b	ed	CHRANCE	and !!	la	~				1 🗆	Yes 2 No	3 ☐ Prob	ably 4 Honknown
ecc	e law r has be je 2 sh	Completed	3Tester	~~						24a. Was		b. Were auto	psy findings available inpletion of cause of
<u>=</u>		5								perfo	2 No	death? 1 ☐ Yes	
Vita	Physician: Th rthis certificate ral director, pag	Be (	25. Was case referred to medica examiner?			/			. Place of De	ath (Check only o	ne)		
or	di S	은	1 Yes 2 No	Hospital: 1 ☐ Inpatie		R/Outpatie			4 ☐ Nursing H	Home 5 ☐ Resi			/)
n C	ing Affer une	ion:	27. Manner of Death  1 ☐ Natural 5 ☐ Pendin			28b. Time o Injury		Injury at Work?	O D No	28d. Describe	how injury occ	curred	
Division	at at	icat	2 ☐ Accident investigned investigation investigned investigation investig	not be	urv - At ho	me. farm. st			2 🗌 No	28f Location /	Street and Nu	mher or Rura	l Route Number,
Ω	after after I Dire	Certification:	4 ☐ Homicide determ	building, et	c. (Specify	)				City or To		and of real	Troute Hambon,
	To the Hospital or Attuvithin 24 hours after de To the Funeral Directo completely filled in by the		29a. Certifier 1 Certifyir	ng Physician: To the best Examiner: On the basis o	of my know	wledge, deat	th occurred at the	ne time, o	date and plac	e, and due to the	cause(s) and	manner as s	tated.
	thin 24 the F	Medical	one)	and manner sta	ated.								
	Si A Ki		29b. Signature and title of cortice	Haz 1			-	cense nu	1 /		()	ned (Month,	Day, Year)
	2		20 Name and address	Who completed	neth ():	00-1/7	Daint)	7	54		_	7720	7 3
(	104		9135 1180	who completed cause of d	eath (Item	23a) (Type	parle	M	into	cmo	207	37	
t	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture K	had.						
	Regist	al	JUL Z	9 2008	ue.	15 /	gover .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 2008 Dallas Marie July 23, 8:45 A. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Ye Dec. 24, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1 □ M 2 🗓 F Director 213-40-6133 68 1939 W. Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mudical Evaninat must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐Yes 2 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9928 Canvasback Way 20872 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Be Completed by 1 ☐Yes 2X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Hairdresser Beauty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jackie Gray Violet Pugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Watson Marlow III - Son 4821 Buxton Circle, Owings Mills, Maryland 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Metropolitan Crematorium 7/25/Q8 Alexandria, Virginia 21. Signature of Funeral Service Licensie 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home Kovert 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia 14 Days /Medical Due to (or as a consequence of): **Examiner** Interstitial Lung Disease Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Endstage Lung Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**∑** No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D0062435 July 23, 2008

State Registrar

DHMH 17 Rev 1/2001

Medical Center Drive,

Rockville, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10110

32. Registres Signature

Sayed Elsayyad M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY **Physician** PETER H. BEECK 2008 11:36PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours **™** M 2□F 67 096-32-4743 OCT 12, **Director** 1940 **GERMANY** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203M SECRETARIAT DRIVE 21078 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE SCHOOL 12 CARPENTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRITZ FALKENBERG INGEBURG HOPPE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY L. BEECK / SPOUSE 203M SECRETARIAT DRIVE, HAVRE DE GRACE, MD 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐Removal from State 7/29/08 4 ☐ Donation 5 ☐ Other (Specify) R.A. FERRIS & CO. WEST CHESTER, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME coloman 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a nsequence of): Examiner arthusis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Diahetus as the burial-transi Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No Division or Vital 25. Was case referre to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2**N**0 2 ER/Outpatient 3 DOA Certification: To 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 V Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō 24 hours a 29a. Certifier 🗹 Certitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP6 MIM Day, Year) State 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:30 a.m. 22, 2008 CALE BURWELL July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Buckinhams Choice Adamstown Frederick 8. Date of Birth (Month, Day, Year June 15, 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2√€ F California 74 1934 250-48-2005 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 🙀 ☐ No Director Maryland Frederick Adamstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number and 2 should be filed within 72 hours after death with teath and Mental Hygiene. m 27 is marked other than "natural", or Items 23a or ; USA 21710 3130 Chartwell Crescent Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify Specify: **3** Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) the Education Tutor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Manley Hale Simons Louise Bedell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health at Important: If Item 27 is any Injury or other trau once. 7113 Sycamore Avenue, Takoma Park, Maryland 20912 Frances Burwell - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Stauffer Crematory 7-25-2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 Marion 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 months disease or condition resulting in death) MPTOSTOHC avorion Cancon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician sthe burial P.O. Box 68760 Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) Yes ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Deston 8 cm 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate 1☐ Yes 2 Physician; 25. Was case referred to medical uneral director 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2No 1 Yes P 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending Injury within 24 hours after occurrent to the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check o one) and manner stated 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Hiren Shah Johnson Dr Frederick Thomas

State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 25630 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Bryan Bell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicom IC REGIONAL 54/1564n Teninsula Centa Mediene If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) cial Security Numbe Date of Birth (Month, Day, **Funeral** Days 1 **⊠** M 2 □ F Hours Min 215-26-7423 5/10/1933 75 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show, event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 Moore Ave. 21826 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Extending ONCE. 1 ☐ Never Married 2X Married 1 □Yes 2 No Specify: þ 3 Widowed 4 Divorced Army white Completed altimore, Maryland 21215-0 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) truck driver Moore Business Forms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Emory Bell Ethel Mae Potts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillie Mae Bell/wife 116 Moore Ave., Fruitland, MD 21826 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Eastern Shore of MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/29/08 Hurlock, MD Veterans Cemetery 22 Holloway Funeral Home Professional Association Signature of Funeral Service Licensee 501 Snow Hill Rd., Salisbury, MD 21804 CFSP arramos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOM **Physician** OPATH /Medical Due to (or as a consequence of): Examiner A20 cars Sequentially list conditions, any configuration of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2. No certificate ha 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manual of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death.

Director: Afted in by the funethere 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital of within 24 hours af to the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10m State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryl		artment of F rtificate of		Reg	ene g. No. 2008	3 2563		
Physicia /Medica Examine	n al	1. Decedent's Name (First, Middle, La  4a. Facility Name (If not institution, giv	BOYCE	L	4b, City, Town, o	or Location of Dea	2. Date of Death	Day ZOOS  4c. County of Death  Baltimore			
Funeral Director		5. Social Security Number 6. S 221-18-7501 Usual Residence of Decedent		yrs. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. Birth	pplace (State or Foreign untry) ryland		
the Maryland 28a-f show cotified at		10a. State 10b. County DE Sussex  10e. Street and Number	100	City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 📉 No		
peritinicity, Mal ylatin 2 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ral Di	32583 Pine Grove  11. Marital Status  1 □ Never Married 2 □ XMarried	Rd.  12. Was Decedent Ever Armed Forces? 1 □ Yes 2X No	in U.S. 13.	10f. Zip Code 199. Was Decedent of H If Yes, specify Cub			USA 14. Race - Amer	zen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White and of Business/Industry  Home  Surname)		
n 72 hours aff "natural", or edical Exami	۵	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gra	16a. Dece	1 ☐ Yes 2 ☐ No edent's Usual Occup e kind of work done DO NOT use retire	Specify:  pation during most of wo	orking					
diric 212  be filed withintal Hygiene. ed other than event, the M	m	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last Norman Allen	College (1-4or 5+)		omemaker	18. Mother's Na	ame (First, Middle, Ma	Home aiden Surname)			
; Mal yie and 2 should ealth and Me n 27 is mark her traumatic	<u>°</u>	19a. Informant's Name/Relationship ( Dale Boyce /Husb	and	3258	33 Pine G	and Number or F	red Eddy Gural Route Number, o d Laurel,		iip Code)		
permit. Pages 1 Department of H Important: if fter any Injury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lices	Removal from State	Odd Fell	osition (Name of ematory or other place)  OWS Ceme 1  2. Name and Addre	tery 7-2		aurel, Del	laware		
Physician /Medical Examiner	edical Examiner	23a. Part1. Enter the isease, or comshock, or hear failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the one cause on each line.  a. Due to (or as a cor)  b. Due to (or as a cor)  c. Due to (or as a cor)  d	death. Do not en		ng, such as cardia			Approximate Interval Between		
the death certily the attending ached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnanc □ Other (specify) _	у			*		
v requires that been signed the should be deti	2	Part II. Other significant conditions of	contributing to death but not	resulting in the u	ınderlying cause giv	ven in Part I.		cco use contribute to			
an: The law difficate has letr, page 2 s	Be Completed	25. Was case referred to medical				26. Place of De	24a. Was an autopsy performe 1 Yes 2 [	prior to co death? ✓No 1 ☐ Yes	opsy findings available ompletion of cause of		
Physical this call dire	0	examiner? 1	28a. Date of Injury (Month, Day Yea		of 28c. Injur Wor M 1	ner: 4□ Nursing I ry at	Home 5 ☐ Residen 28d. Describe how	ce 6 Other (Special injury occurred let and Number or Rule)			
To the Hospita within 24 hours. To the Funeral completely filled	edical	29a. Certifier (Check only one)  29b. Signature and title of certifier	nysician: To the best of my niner: On the basis of exame and manner stated.	r knowledge, dear mination and/or in	th occurred at the tinvestigation, in my o	opinion, death occ	curred at the time, dat	e and place, and due  d. Date signed (Month	to the cause(s)		
Stat Registra	е	30. Name and address of person who SEPL (31. Date filed (Month, Day, Year)	completed cause of death	301 57	Print) PAUL	PLAC	E BA	CTIMORE.	9, 2008 SASIS UM		

State of Maryland / Department of Health and Mental Hygiene 2 0 0

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**Physician** /Medical **Examiner** 

**Funeral Director** 

BROWN, COLUBEN

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit completely filled in by the funeral director, page 2 should be detached for use as the burlan-transit After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi

Division of Vital Records, P.O. Box 68760,

Be Completed by Funeral Director ၀ Medical Certification: To Be Completed by Physician/Medical Examiner

1 - For State Registrar		State of Ma	ryland / D	epartment o Certificate d	i Health ai of Death	nd Mental H	ygiene 2 (	008	25637
1. Decedent's Nan Colleet	ne <i>(First, Middle, La</i> n Ma <b>ri</b> e	Brown				2. Date of D Month		o O X	3. Time of Death  3. 3. PM
-		restreet and number)	ital		n, or Location of kville	Death		y of Death	
5. Social Security 219–54–8	8644	ex ☐ M 2 <b>X</b> ☐ F	(In yrs. last birth	nday) If Under 1 Years. Months Da		Min. (Month, L	Birth (Pay, Year) 30, 1947	9. Birthp Coun WA	lace (State or Foreigr try)
Usual Residence of	of Decedent 10b. County		10c. City, Town	or Location		<u> </u>			0d. Inside City Limits
MD	Montgo	nery		Gaithersb	urg				1 □Yes 2 🛣 No
10e. Street and Nu	1			10f. Zip Coo			10g. Citizen of	What Coun	itry?
217 Boo	th Street				20878		Unite	d Stai	tes
11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed	ried 2 Married	12. Was Decedent E Armed Forces? 1		13. Was Decedent If Yes, specify C		n? (Specify Yes or N Puerto Rican, etc.)		ce - Americack, White, e	etc.
(Spe	15. Decedent's Ed	flucation ade completed)	16a. [	Decedent's Usual Oc Give kind of work do life. DO NOT use re	cupation ne during most o	of working	16b. Kind of B	Business/Ind	dustry
Elementary/Sec	ondary (0-12)	College (1-4or 5+	-)			Ü	Falan	-1 0-	
17. Father's Name	(First, Middle, Last)			Secretary		s Name (First, Middi			vernment
Robert	Morton Di	llon			Mary	Charlotte	Beeson	,	
1	lame/Relationship (		19b. I	Mailing Address (Str				, State, Zip	Code)
Heather	Coleman/D	aughter	130	)18 Prairi	e Knoll	Court,Ge	rmantown	, MD	20874
20a. Method of Dis 1 Burial 2 4 Donation		Removal from State	Metropo	Disposition (Name of Crematory or other Litan matory	olace) Ju	11y 25 2008	20c. Location	,	wn, State  Virginia
21. Signature of F	uneral Service Licer	0041		22. Name and Ad	ıneral H	ome, 10 E sburg, MD	ast Deer		
23a, Part 1. Enter shock, or he Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to ir cause. Enter Und. Cause (Disease of that initiated event resulting in death)	(Final on on on on on on on on on on on on on	b. Due to (or as a	consequence of	ilene	dying, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	months?	23c. If yes, outcome of 1 Live birth 24 Pregnant at 19 Unknown	Fetal death	3 ☐ Ectopic pregn 5 ☐ Other (specify				ate of delive	ery Day Year
Part II. Other signi	ificant conditions c	ontributing to death but	not resulting in t	he underlying cause	given in Part I.		tobacco use cor		ne cause of death? eably 4 🗌 Unknown
25 Was associated				~-		per 1 □ Yes	opsy formed? 2 A No	Were auto prior to cor death? 1 ☐ Yes	psy findings available npletion of cause of 2  No
25. Was case refe examiner? 1 ☐ Yes 2 [2]	No medical	Hospital:	4 0 D EB/0-4-	-111 0 7 504	Other:	f Death (Check only			
27. Manner of Dea		1 Inpatien 28a. Date of Injury	/ 28b. Tir	me of 28c. I	niurv at	ing Home 5 Res	sidence 6 ∐Ot e how injury occu		y)
1 Natural 2 Accident	5 Pending investigation	(Month, Day,	Year) Inji		Vork? □Yes 2□No				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	n, street, factory, office	ce	28f. Location City or To	(Street and Num own, State)	ber or Rura	l Route Number,
29a. Certifier (Check only one)	Certifying Ph	ysician: To the best of hiner: On the basis of and manner state	examination and/	death occurred at th for investigation, in n	e time, date and ny opinion, death	place, and due to the occurred at the time	ne cause(s) and n e, date and place	nanner as s , and due to	tated. the cause(s)
29b. Signature and	und (	Unnale		29	ense number		11 //	ed (Month, 2)	
30. Name and add	ress of person who	completed cause of dea		ype, Print) SPOVE PO	ROCKE	KLEMO L	OIRO		

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

28

32 Registrar's Signature

PROPOSE TO BE STREET TO BE STORY OF THE WORLD FOR THE WORL	or Foreign
4a. Facility Name (If not institution, give street and number)  11608 Ful ham Street  Silver Spring  Montgomery  5. Social Security Number  052-18-3577  Director  4b. City, Town, or Location of Death  Silver Spring  Montgomery  15. Age (In yrs. last birthday)  16. Sex  17. Age (In yrs. last birthday)  17. Age (In yrs. last birthday)  18. Date of Birth (Month, Day, Year)  19. Birthplace (State Country)  Austria	ity Limits
Ligual Regidence of Decedent	
106. Street and Number 107. Table 108. Street and Number 108. Street and Number 109. Citizen of What Country? 1109. Citizen of Noricen of What Country? 1109. Citizen of Noricen	
The part of the pa	
To Father's Name (First, Middle, Last)  Joseph Berman  Joseph Berm	
Esther Berman Hornestay, Daughter 11608 Fulham Street, Silver Spring, MD 209	
20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) 20c. Location - City or Town, State	)2 
20a. Method of Disposition  1 Burial 2 Cremation 3 Nemoval from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Beth Israel Cemetery  20c. Location - City or Town, State  4 Donation 5 Other (Specify)  21. Signature of Fureral September 1 Signature of Fureral September 2 Signature of Fureral September	
254 Carroll St., NW, Washington, DC 20012  23a. Part Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)   Atherosclerotic Cardiovascular Disease   Years and the cause (Final disease or condition resulting in death)   Due to (or as a consequence of):	tween
Sequentially list conditions, if any leading to the modulation of the property	
The state of the s	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of 1 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 yes 3 probably 4 yes 2 yes 3 probably 4 yes 2 yes 3 probably 4	
The second of th	available ause of
C D Describe now injury occurred Home	
29a. Certifier (Check only one)  29a. Certifier (Check only one)	s)
30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)	
Raymond White, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910  State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature	

DHMH 17 Rev 1/2001

			For State Registrer	State	of Marylar			nt of H		and M	ental H	ygier Reg. 1	20	08	25	634
	Physicia	an	1. Decedent's Name (First, Middle,	Last)							2. Date of I Month		Day	Year	3. Time of	
	/Medic	al	Thomas Barrett							-	July 2		2008		1:30	РМ
	Examin	er	4a. Facility Name (If not institution,						Location o	of Death			4c. County of	_	۵1	
		D.	Anne Arundel Med 5. Social Security Number	.Sex	nter 7. Age (In yrs.	last birthday)		apoli: er 1 Year		24 Hrs.	8. Date of E		Allile F		lace (State o	or Foreign
	Funeral Director	1	218-28-9080	1 <b>∑</b> M 2□F	74	Yrs.	Month		Hours	Min.	(Month, I	Day, Yea	1933 M	Coun	trv)	. oragn
	D		Usual Residence of Decedent													
	anylar	_	10a. State 10b. County			ity, Town or Lo	ocation							1	0d. Inside Ci	
	Ba-f	Director	Maryland Prince	e George	's Se	abrook									1X Yes	2   NO
	with ti		10e. Street and Number					Lip Code					Citizen of W	/hat Coun	try?	
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3	ei', o	þ	3 XWidowed 4 □ Divorced	If Yes, G Year or I		55	1 🗆 Yes	2 💢 No	Specify:				Specify:	Whit	e	
213-0030	72 hours after death with the Maryland Insture!, or iteme 23e or 28e-f ehow dical Examinal must be notified at	Completed	15. Decedent's (Specify only highest		)	16a. Dece	dent's Us	sual Occupa	ation furing most	t of workii	na	16b.	Kind of Bu	siness/Ind	dustry	
V	Athin ne. hen	idu	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT	use retired	)						s Sena	
7	lied v lygie ther ti nt, in		17. Father's Name (First, Middle, La	etl		Supe	rint	endan		rde Nama	(First, Midd				rnment	-
yiand	d be intal h	) Be		31/					Iren			ire, maiu	en sumam	8)		
<u> </u>	should nd Me mark mati	ဥ	Jerome_Burns  19a. Informant's Name/Relationshi	(Type, Print)		19b. Maili	na Addre	ss (Street a			W LS I Route Nun	nber Cit	v or Town	State Zin	Code)	
Z Z	nd 2 lith ar 27 is r frau		Thomas Burns, J								Ellico					
ē,	s 1 a of Hea item		20a. Method of Disposition		20b.	Place of Dispo	osition (A	ame of	e)	D	ate	20c.	Location -	City or To	wn, State	
Ē	Page nent c ant: if ary or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	Maryl terans	and Cem	eterv		7/25	/2008	Cro	ownsvi	i11e,	MD	
sammore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or iteme 23s or 28s-f show may finury or other traumatic event, the Medical Examination must be notified at once.		21. Signature of Funeral Service Li	enson											al Ho	ne
_	20E 29		· kull				1600	0 Ann	apoli	s Ro	ad Bov	vie,	MD 20	0715		
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	omplications that nly one cause on	caused the dee each line.	th. Do not en	ter the m	ode of dyin	g, such as	cardiac o	r respiratory	arrest,			Approximat Interval Bet	ween
Ì,	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Dueu	monia									day S	Jean
	/Medical Examiner		rosuming in additity	Due to	(or as a conse	quence of):										
	# <b>4</b>   ==     •	P-	Sequentially list conditions, if any, leading to immediate	b	(or as a conse	quence of):										
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	8												
o î	be executed ician and burial-transit	Еха	resulting in death) Last	C. Due to	(or as a conse	quence of):										
2/00	cate be executed physician and the burial-transit	dicai		d												
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XOD D	death co	ician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregr birth 2 ☐ Fet	al death 3[		pregnancy					23d. Date Mor			Year
	the a	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□ Unki	nant at time of	death 5[	Other	specify)				-			,	
, .	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as	Ph	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	ınderlying	cause give	en in Part I.		23e. Di	d tobacc	o use contr	ibute to th	ne cause of c	death?
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io Sa	s bee	Completed									24a. W	as an	24b. V	Vere auto	psy findings	available
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VIII		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check on/		100		20110	
5	hysic his ce Il dire	2	1 ☐ Yes 2 No	-4		ER/Outpatie	nt 3 🗆	Othe Othe	9r: 4 □ Nu	irsing Hor	me 5□Re	sidence	6 □Othe	er (Specify	v)	
	ding Ph h. After th funeral	on:	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date (Mo	of Injury oth, Day Year)	28b. Time o Injury		28c. Injury Work			28d. Describ	e how in	njury occurre	ed		
VISION	tend death for: /	cat	2 Accident investigat 3 Suicide 6 Could no	t bo			М		Yes 2 1		2011	/0:				
5	or A efter Direction by	ertification:	4 ☐ Homicide determin	ed 28e. Place build	e of Injury - At t ting, etc. (Spec	ify)	reet, fact	ory, office		4		Cown, St		er or Hura	l Route Num	iber,
_	To the Hospital or Attending Physicien: To the Funerel Director: After this certifica completely filled in by the funeral director.	O	29a. Certifier 1X Certifying	Physicien: To th	e best of my kn	owledge, deat	h occurr	ed at the time	ne, date an	d place a	and due to the	10 Cause	a(s) and ma	nnerase	lated	
	ne Ho 1 24 t ne Fui	edicai	one) 2 Medical E	aminer: On the and ma	basis of examin nner stated.	ation and/or in	vestigati	on, in my op	pinion, deal	th occurre	ed at the tim	e, date a	and place, a	and due to	the cause(s	;)
	To the within To the comp	Me	29b. Signature and title of certifier		Red.	410	2	9c. License	number			29d. I	Date signed		Day, Year)	
)	-x/DO	7	•	wend	Acr 1	W		D	16057	2			7/22	2108		
1	(C)(A)		30. Name and address of person w  Signed Beck  31. Date filed (Month, Day, Year)	no completed cau	se of death (Ite	m 23a) (Type,	Print)	0.	ha I h	ls	MO					
	/X		31 Date filed (Month Day Vace)	20	Majetrario Ci-	- COL 100	NWY	,	Lo.	~,1	V1/					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 25635

David Jet	ffrey Bau		State of Mar For <b>S</b> tate	yland / Depar <i>Cert</i>	tment of <i>ificate of</i>	Health	ano ivi	ientai mygi	Reg. 1	do.	200 200
		R	gistrar Decedent's Name (First, Middle,Last)	Cert	meate of	Boutin			Date of Death		3. Time of Death
Me	`hysicia ≟xamir	-	Day	vid Jeffre				J	Month Da uly 22, 2008	3	0354 hrs
			a. Facility Name (if not institution, give street ar	nd number)		4b. City, Tow		tion of Death		4c. County of Dea Frederick	ath
			Frederick Memorial Hospital	13 A - (1 10	-t hirdhdou\	Frederic		Under 24Hrs. 8	. Date of Birth(N	. ( D 2 2 2 2 2 4 7 1	Birthplace (State or
	uneral	2	Social Security Number 6. Sex	7. Age (In yrs. la	52	Months		lours Min.	March 20	1956 For	eign Washington,
D	irector	Ž	1 <u>X</u> M 2_	F -	54 Yrs	S			March 1	<del>9, 1994</del>	2.0
	ny		sual Residence of Decedent  0a. State 10b. County	10c. City,	Town or Loca	tion					10d. Inside City Limits
7	10 W 8		Maryland Frederick		Frede	rick					1 X Yes 2 No
1	8a-fsl		0e. Street and Number			10f. Zip C				Citizen of What C	
	death with the Maryland or items 23a or 28a-f show any must be notified at once.	ă	90 Waverly Drive			1	702			United S	tates nerican Indian, Black,
	ms 23	era	A see	s Decedent Ever in U. ned Forces?	S. 13. W	as Decedent Yes, specify	of Hispan Cuban, <b>M</b> e	ic Origin? ( Spec exican, Puerto Ri	can, etc.)	White, etc	
-	or ite	Funeral		Yes 2 X No	1	Yes 2 X	No sa	pecify:		Specify:	white
	hours after 'natural", Examiner	≦-	Widowed 4 Divorced in Yes, Gi or Dates: 15. Decedent's Education (Specify only higher		16a Decede	ent's Usual O	ccupation	(Give kind of wor		6b. Kind of Busine	ss/Industry
	2 hour	홝		ege (1-4 or 5+)			ng lite. DC	NOT use retired		lomo Impu	ovement Store
336	ed within 72 hours afte lygiene.  other than "natural", the Medical Examiner	Completed		1	Cle	rk	140	Mother's Name (F			Ovement Store
5-0036	Hygie I other the N		17. Father's Name (First, Middle, Last)	Jerome Mor	ris Ba	uman	18.1		Ella Go		
2121	d be fi fental arked event,	å	19a. Informant's Name/Relationship (Type, Prin				(Street ar	nd Number or Ru	ral Route Numb	er, City or Town, S	tate, Zip Code)
MD 2	Pages; I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ment of Health and Mental Hygiene. ment: If item 21 is marked other than "natural", or items 23a or 28a-f sht anti: If item 21 is marked other than "natural", or items 23a or 28a-f sht or or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner.	٩	Gloria Bauman, Mothe	r	315	Hannes	Str	eet. Sil	ver Spr	ing, MD	20901
e` o`	and 2 Health item 3	7.0	20a. Method of Disposition	20b.	Place of Disp	osition (Name	e of cemet	ery,	Date	20c. Location - Cit	
nor	Pages l nent of H ant: If it		1 X Burial 2 Cremation 3 Rem 4 Donation 5 Other Specify:	Juc	lean Me	moria		dens 07/	25/08	Olney,	MD
Baltimore,	permit. Pages Department o Important: injury or oth	- 4	21. Signature of Fu aral ervi a Learness	5	22	Name and A	Address of SKV H	ebrew Fu	neral H	łome	
· · ·	P P P		23a. Post 2 Enter the disease, or complications	that caused the death	b_	4 Car	Sing, su	cardida	es Vas Inc	Sheat to head	Approximate Interval Between Onset and
1	/sicían Medical		failure. List only one cause on each line.								Death
	kaminer			le Gunshot Wou or as a consequence							
			Sequentially list conditions, b								
		iner	if any, leading to immediate Due to (	or as a consequence	of):						
-	44	Examiner	(Disease or injury that initiated events resulting in death) Last	(or as a consequence	of):						
	be executed sician and ourial - transit	a E	d								
o o	e be exe ysician burial -	edical		NDED .80erFH.7-30		MrCb_	-			23d. Date of de	alivery
68760	OR Physician: The law requires that the death certificate the third this certificate has been signed by the attending physician direction age 2 should be detached for use as the D meral director, nage 2 should be detached for use as the D.	Ę	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pre Live birth	2	Fetal death	3	Ectopic pregnar	псу	Month	Day Year
9 X	th cert ttendi	Physician/M	past 12 monurs:  1 Yes 2 No 9 Unknown g	Pregnant at time of	death 5	Other (Spe	cify)			1	
Box	he dea y the a hed fo	1 5	Part II. Other significant conditions contri	Unknown	t resulting in the	he underlying	cause giv	ven in Part I.			ute to the cause of death?
0.0	ires that the signed by	<u>۾</u>	Turin outs significant						1 Yes		Probably 4 Unknown
ds.	v require s been signated	Completed							24a. Was autop	sy pri	ere autopsy findings available or to completion of cause of
Ç	e has b	I E							perfo	1122	ath? ✓ Yes 2 No
8	r: The tificate or. pag	ပိ	25. Was case referred to medical					of Death (Check	only one)		
/ita	Physician: The law rethis certificate has be	o Be	examiner?  1 ✓ Yes 2 No	1:1 Inpatient 2	✔ ER/Outpat	tient 3			g Home 5	Residence 6	Other:
- Jo	Jing Phy After th	ے ا	27. Manner of Death	Ba. Date of Injury (Month, Day Year) Jul 22, 2008	28b. Time 0325 hrs			⁄at Work? es 2 ✔ No	Subject sho	how injury occurre it by police	ŭ
	ttendi leath. ttor:	l ŝ	J Fending	8e. Place of Injury - A	1				28f. Location (	Street and Numbe	r or Rural Route Number, City
Division of Vital Records.	l or A after of Direct	Certification:	3 Suicide 6 Could not be	(Specify) Parking		Street, lactor	y, 011100 D		or Town S		
	Hospital or 24 hours afte Funeral Dit	> 1	29a Certifier		ledge death o	occurred at th	e time, da	te and place, and	due to the cau	se(s) and manner	as stated.
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director	Medical	(Check only one) 2 Medical Examiner: On the	ne basis of examinatio	n and/or inves	stigation, in m	ny opinion,	death occurred a	at the time, date	and place, and as	
	Livi S	N N	29b. Signatule and title of certifier	۸		29	c. License				d (Month, Day, Year)
	3		( ) Contorber	W)			O.C.N	√I.೬. 		July 22, 200	<del></del>
			30. Name and address of person who compl	eted cause of death (I	tem 23a)	enn Stree	t Baltin	nore, MD 212	201		
				Medical Examine		SINI OUGE					
		Stat	31. Date filed (Month, Day, Year) 2008	Malue 1	S. As	Select of					

			For State Registrar	State of N	Marylan	d / Depa	artment rtificate	of H	eaith a Death	and M		giene Reg. No		8 0	25636
			Decedent's Name (First, Middle, La	ıst)				-	-		2. Date of De				3. Time of Death
	Physici		Rita Kapoor	Bricks	in						Month July	Da	<sup>y</sup> 21	<sup>Year</sup> 2008	7:30 A M
,	/Medic Examin		4a. Facility Name (If not institution, gire				4b. City. 1	Town, or	Location of	of Death		40		of Death	
	Lxamiii	e.	8606 Melwood		•			hesd				M	lonts	omery	У
7	Funeral				Age (In yrs. I	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th		9. Birthol	lace (State or Foreign
	Director		545-58-9632	1□M 21X1F	77	Yrs.	Months	Days	Hours	Min.	(Month, Da	(V, Year)	930	Indi	try)
			Usual Residence of Decedent				<u>1</u>								
	ylan		10a. State 10b. County		10c. City	y, Town or Lo	cation							10	0d. Inside City Limits
	Mar.	jo	Virginia Fairfa:	x	Fa	irfax	Stati	lon							1 ☐ Yes 2 🛣 No
	r 28	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of V	Vhat Count	try?
	death with the Maryland ms 23a or 28a-f show rmst be rutified at		6812 Old Stone F	ence Road			2	22039	9-184	.5		1	Unit	ed St	ates
	dea	Funerai	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13. \	Vas Decede	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	)-		e - America	
٥	or Its		1 ☐ Never Married 2 Married	1 ☐ Yes 2 If Yes, Give			1 ☐ Yes 2		Specify:	1, 1 00110	rtican, etc.)			k, White, e	AG.
2-003e	oe filed within 72 hours after d la! Hygiene. d other than "natural, or Itam event, I'm Medical Experient.	d by	3 Widowed 4 Divorced	Year or Date:	s:		103 2	LAINO	Specify.				Specify	Asia	ın
ก็	72 h 'natu	Completed	15. Decedent's E (Specify only highest gr			(Give	lent's Usual kind of work	k done d	unna mos	t of worki	n <i>g</i>	16b. K	ind of Bu	usiness/Ind	ustry
7	ithin and and and and and and and and and an	Ę.	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. I	DO NOT use	e retired)	)					<b></b>	
V	led w lygier her ti	S		5+		Eco	onomis	3 C					cono		
yland	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show ovent, If a Modical Expredies must be relified at	Be	17. Father's Name (First, Middle, Last	7							(First, Middle,		Sumarr	16)	
<u>X</u>	2 should be and Mental is marked o	၉		Kapoor						mana					
Mar	2 sh and is m		19a. Informant's Name/Relationship			1	-				I Route Numb				
a) •	and lealtt m 27 her t		Roderick Bricksi	n / Spous					Fenc						VA 22039
	ges 1 of H ita or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from Sta	te CE	lace of Dispo emetery, cren	natory or oth	her place			ate	20c. L	ocation -	City or Tov	wn, State
aitimor	Pag men tant: jury	ļ	`4 □Donation 5 □ Other (Speci		Ft.	Linco	1n Cr	emat	ory	7/25,	/2008	Bre	entwo	ood, l	MD
מ	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e ones.		21. Signature of Funeral Service Lice	nsee	1	1	. Name and			. 91	mple T				
_	₫ □ = <b>6</b> ol		Chora								Rockv		, MD	2085	52
			23a. Part1. Enter the disease or con shock, or reart failure. List/only	plications that caus one cause on each	sed the deeth line.	. Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Alzheim	er's I	Diseas	e								Onset and Death
	/Medical		resulting in death)		as a consequ										
	Examiner		Sequentially list conditions.	b											
	p ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequ	ience of):									
	and trans	ш	that initiated events resulting in death) Last	c											
Š	sien surial		a double of the second of the	Due to (or a	as a consequ	ience ot):									
9700,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the buriat-transit	dicai	•	d											
8	ling p	Me	IF FEMALE:		110135-1										
200	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 🗌 Fetal	death 3	Ectopic pre						23d. Dat Mo	e of deliver	ry Day Year
- 5	the a	sic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5	Other (spe	cify)							
Ċ	w requires that the death certific been signed by the attending f should be detached for use as	Physiclan/Me	Part II. Other significant conditions	contribution to dooth	but not soon	lting in the	ded in a		a in Oant I		220 Did t	abaasa i	100 0001	ibuta ta th	e cause of death?
ń	signe be c	þ	Fatti, Other significant conditions	contributing to death	Dut not resu	nung an une ur	ideriying ca	use give	nın Panı.	•					ably 4 Unknown
colds,	neen	ompleted									, ,	Yes 2	r <sup>3</sup> X IAO	3 1 1 1000	
בַּ	law las b	lg l									24a. Was autor	OSY	24b. \	Were autop	sy findings available apletion of cause of
_ =	sician: The law certificate has b irector, page 2 s	Col										rmed? 2⊠No		leath? ☐ Yes	
ום	ysician: is certific director,	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)			
	> .º 0	၉	1 ☐ Yes 2 🖾 No	Hospital: 1 🗆 Inpa		ER/Outpatien	3 □ DO	Othe	r: 4 □ Nu						Daughter's
=	ng P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, L	njury Day Year)	28b. Time of Injury	28	c. Injury Work	at ?	2	28d. Describe I	how inju	ry occurr	ed	Home
	andi eath. or: A the fu	cati	2 ☐ Accident investigatio	1			М	1 □ Y	'es 2 □ l	No					
Ž	r Att	Certificati	3 Suicide 6 Could not be determined	286. Place of I	Injury - At ho etc. (Specify	me, farm, stre	eet, factory,	office		2	28f. Location (3 City or Tox	Street an	nd Numb	er or Rural	Route Number,
ב	ral D									{					
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edicai	(Check only 2   Medical Exa	nysician: To the bearing the basis	of examinat	vledge, death ion and/or inv	occurred a	t the time	e, date and	d place, a	and due to the ed at the time.	cause(s)	and ma	nner as sta	ated. the cause(s)
	tha I tha I tha I	Med	une)	and manner	stated.										
)	To tha Hospital or Attanding Phenith 24 hours after death. To tha Funaral Diractor: After the completely filled in by the funeral	-	29b. Signature and title of certifier	6	2~	-			number				-	i (Month, E	
	(		VIVICE (	0101040504 July 21, 2008											
	12		30. Name and address of person who												
			Marc Eisenbaum,	M.D. 3	700 J	seph S	Siewic	ck D	r. #2	203;	Fairfa	x, V.	A 22	033	
	Sta Registra		31. Date filed (Month, Day, Year)  JUL 2 5 20		strar's Signat										
	negistr	all	JOF % 9 CO	08 1000	1. S.	1300	de la								

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tra
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		For State		State	of Maryla	nd / Depa	artmen rtificat				Mental Hy	ygiene	້ 2 በ	0.8	2	5637
		Registrar  1. Decedent's Nam	ne (First, Middle	. Last)			liiicali	e or L		,	2. Date of D		,, = 0			Time of Death
ysici		Nathan I		,,							July 2	Da	008	Year		:50 A M
Medic camin		4a. Facility Name (		, give street and nu	ımber)		4b. City,	Town, or	Location	n of Death	July 2			of Death		100 11
ann	C.	Casey Ho			,		Ro	ckvi	11e			1	Mont	gome		
eral ector		5. Social Security N 579-05-8		6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	Hours	er 24 Hrs. Min.	8. Date of B (Month, D Feb. 6	Day, Year)	19			State or Foreign
Ħ		Usual Residence o 10a. State	Decedent 10b. County		10c. C	City, Town or Lo	cation						_		10d. ln	side City Limits
fled	to	MD	Montg	omerv		Silver	Sprin	Q							11	XYes 2 □ No
a not	Director	10e. Street and Nu		J J			10f. Zip					10g. Ci	tizen of	What Co	untry?	
15 TH		3174 Add	derley (	Court				2090	6			U.S	.A.			
E.	Funeral	11. Marital Status		12. Was Dec	edent Ever in orces? Arm	U.S. 13.	Was Deced	dent of His	spanic C	Origin? (Sp	ecify Yes or N Rican, etc.)	lo-		ce - Ame		tian,
any injury or other traumatic event, the Medical Experiment sust be notified at once.	þ	1 ☐ Never Marr 3 🔀 Widowed		ed 1 ∑Yes If Yes, G Year or [	ZUNOA1	rcore W2	1 ☐ Yes		Specif					y: Wh		
lical 8	ted	(\$200	15. Decedent	's Education of grade completed)		16a. Dece	dent's Usua kind of wor	al Occupa	ation	ant of wark	ina	16b. K	(ind of B	usiness/l	Industry	
Tre Med	Completed	Elementary/Seco			1-4or 5+)	Merch	DO NOT us	se retired,	)	ost of work	mg	т	iquo	۰r		
ent, I	Be C	17. Father's Name	(First, Middle, i		<u> </u>	Mercii	all		18. Mot	her's Name	e (First, Middl					
ic ev	To B	Samuel I	Burak						Gre	ena l	Koberni	ick				
umat	-	19a. Informant's N	lame/Relations	nip (Type. Print)		19b. Mailii	ng Address	(Street a	and Num	ber or Run	al Route Num	ber, City	or Town	, State, Z	zip Code	·)
er tra		William	S. Bur	ak - Son		10724	Stap	lefo:	rd H	lall I	rive	Poto	mac,	MD	208	54
or othe		20a. Method of Dis		3 ☑ Removal from		Place of Dispo cemetery, crei	sition (Nan	ne of ther place	e) :	[	Date	20c. L	ocation	- City or	Town, S	tate
ulan		4 ☐ Donation	5 ☐ Other (Sp	pecify)		sh. Heb					/2008			gton		
any l		21. Signature of Fi	W.C.	Stottle	muer		OX D	CKVI	тте	PIKE	Memori Rocky	/ <b>T</b> TTE	hape , MI	1s, 0 208	Inc. 352	•
cian lical		23a. Part 1. Enter to shock, or head immediate Cause disease or condition resulting in death)	(Final	a	cau od the dece each line. ver Can (or as a conse	cer	er the mod	le of dying	g, such a	as cardiac	or respiratory	arrest,			Inter	roximate val Between et and Death
iner	ner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Jiscase of	onditions, nmediate	b. Due to	(or as a conse	equence of):										
the burial-transit	Examine	that initiated events resulting in death)	S	c	(or as a conse	equence of):										
s the bi	edical		\$ 22.40.	d						<del></del>						
completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	nonths? □No	1 ☐ Live	atcome of preg birth 2□ Fe gnant at time o nown	tal death 3	∃Ectopic p ∃Other <i>(sp</i>		,					ate of deli	ivery Day	Year
d be deta	þ	Part II. Other signi	ficant condition	ons contributing to c	leath but not re	esulting in the u	nderlying c	ause give	n in Par	t I.						use of death?
e 2 shoul	Completed					-					24a. Wa		_	Were au	itopsy fii	ndings available ion of cause of
r, pag											1 □Yes		0	death? 1 ☐ Yes	2 🗆 1	No
recto	Be	25. Was case reference examiner?	_	Hospital:				Othe			h (Check only				TT -	
aral di	: To	1 ☐ Yes 2 ∑		28a. Date		ER/Outpatie		28c. Injury			ome 5 Re				cify)HC	spice
e fune	ation	1 X Natural 2 ☐ Accident	5 ☐ Pending investig	gation (Moi	nth, Day, Year)	Injury	м	Work	?" /es 2[	ŀ	Edu. Describe	s now myo	iry occur	iiou		
ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	ined 28e. Place	e of Injury - At ling, etc. <i>(Sp</i> e	home, farm, str	eet, factory	, office			28f. Location City or To	(Street a own, Stat		ber or Ru	ıral Rou	te Number,
letely fill	Medical (	29a. Certifier (Check only one)	✓ CertifyIn 2 Medical	g Physician: To the Examiner: On the and mar	e best of my k basis of ex mi nner stated.	nowledge, deat nation and/or ir	h occurred vestigation	at the tin	ne, date pinion, d	and place, leath occur	, and due to the red at the time	ne cause( e, date ar	s) and m	nanner as , and due	s stated to the	cause(s)
two	Me	29b. Signature end	d title of certifier	Wi		2		. License		r		29d. Da	_	y 24		
		30. Name and add		who completed cau Wroblews			Print)			e Ro	ckville	e, MI				
Sta egistr		31. Date filed (Mor		32	Registrar's Sign	nature						,		-		
				1	AND THE PARTY OF	1 1	- Springer									

08-05871 James Brooks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Poeparine near health and Mental Hygiene

		1-For State Registrar	Certificate	of Death		.c., , , , g. c c	Reg. No. 20	008 2563
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last)  JAMES MICHAEL BROOKS				2. Date of De Month July 31, 2	Day Year 2008	3. Time of Death 2250 hrs
Mr. A.Z.		4a. Facility Name (if not institution, give street and number) Shady Grove Hospital		4b. City, To Rockvi	wn, or Location of lie	of Death	4c. County of D Montgomer	
Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 1 M 2 F	e (In yrs. last birthday	y) If Under Months	1 Year If Unde		irth ( <b>MY98/0</b> 777) 9.	Birthplace (State or Foreign Country) MD
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
<b>*</b>	ь	MD MONTGOMERY	POOLI	ESVILL	Е			1 Yes 2 X No
with the Maryland ns 23a or 28a-f sho	Director	10e. Street and Number 20301 WESTERLY ROAD		10f. Zip 0	0837		10g. Citizen of What (	A
after death with the Maryland al", or items 23a or 28a-f she iner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Armed Forces? 3 Widowed 4 Divorced If Yes, Give Year	No No	If Yes, specify		jin? ( Specify Yes or N , Puerto Rican; etc.)	White, et	merican Indian, Black, cc. HITE
ours aft	d by	15. Decedent's Education (Specify only highest grade con	npleted) 16a. Dece	edent's Usual O	ccupation (Give	kind of work done	16b. Kind of Busine	
036 ithin 72 h ne. r than "n	Completed	Elementary/Secondary (0-12) College (1-4 or :	5+)	ALTOR	ng life. DO NOT	use retired)	REAL E	STATE
5-0 Bled w other		17. Father's Name (First, Middle, Last)			18.Mother	's Name (First, Middle,		
21215-( 21215-	o Be	ROBERT LEWIS BROOKS,  19a. Informant's Name/Relationship (Type, Print)		ailing Address		EBECCA SE		State, Zip Code <b>2</b> 0 8 3 7
AD 2 sho 1 and 27 is		REBECCA SELBY / MOTHER	₹   21	1311 W	HITES E	FERRY RD.	, POOLES	VILLE, MD
2 - E E E		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:		ER CREI	MATORY		20c. Location - Cit 8 FREDE	y or Town, State RICK, MD
		21. Signature of Fun all Stryce Licensee		HILTO		RAL HOME		ILLE, MD
Physician /Medical Examiner	ĺ	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a conse	artery thi			ardiac or respiratory a	rrest, snock, or neart	Approximate Interval Between Onset and Death
	ا	Sequentially list conditions, b						
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	-					
ecuted and and		events resulting in death) Last Due to (or as a conse	· ·					
<u>a</u> <u>a</u> . ĕ	/Medical	X UNPENDED X AMENDED X	<b>a,PII,2/,p</b> tem#8,perF	perME, 8 FH,G882	<b>883 8 /</b> 8/13/08	1 <b>2/08 TT</b> ,WS		
,=		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcor	me of pregnancy	Fetal death	3 Ectopic		23d. Date of del Month	ivery Day Year
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician	1 Yes 2 No 9 Unknown g Unknown	time of death 5	Other (Specif	(y)			A.
P.O. Es that the c		Part II. Other significant conditions contributing to deat	n but not resulting in t	the underlying o	ause given in Pa			e to the cause of death?
Is, P.C quires that en signed t	ted by	Cocaine use				_		Probably 4 V Unknown
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seed in by the funeral director, page 2 should be	Completed					24a. Was auto perf		e autopsy findings available to completion of cause of h?
ital Recition: The sector, page	S e	25. Was case referred to medical		2€	Place of Death	(Check only one)	2 No 1	Yes 2 No
Vita hysicia this ce	0 B	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatie	ent 2 🗸 ER/Outpat	parameter (	Othor	Nursing Home 5	Residence 6 C	Other:
n of \ding Phy. h. After tl	on: T	27. Manner of Death  1 X Natural  5 Pending  28a. Date of Inju (Month, Day, Y	ury 28b. Time 'ear)	of Injury 28	c. Injury at Work	1	how injury occurred	
r Attend r Attend ter death irector: n by the	ficati	2 Accident Investigation	ijury - At home, farm, :	street, factory, o			(Street and Number o	r Rural Route Number, City
Divis spital or At tours after d neral Direct filled in by	Certification:	4 Homicide determined (Specify)				or Town,	State)	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical	29a. Certifier 1 Certifying Physician: To the best of mone) Certifying Physician: To the best of mone Certifying Physician: To the basis of examiner: On the basis of examiner:						
To To Con	Me	29b. Signature and title of certifier		29c.	icense number		29d. Date signed	(Month, Day, Year)
		anes 2			O.C.M.E.		August 1, 200	08
		30. Name and address of person who completed cause of d Ana Rubio MD. Assistant Medical Exam	,	n Street, Ba	Itimore, MD	21201		
		31. Date filed (Month, Day, Year) Registra		will				-
Regist	rar	AUG 0 8 ZUU8	San San San San San San San San San San	- Water		2011		

08-05764

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

icia Bair	R	egistrar	artment o rtificate o			Reg.	No. 20	08 256
Physician	1/	Decedent's Name (First, Middle,Last)			2	Date of Death  Month  D	Day Year	3. Time of Death 0955 hrs
dical Examin		Patricia Lynn Bair  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	July 28, 200	4c. County of Dea	
	Í	438 Ocean Parkway Unit 39	ŀ	Ocean Pines	outon of Beauty		Worcester	
* Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year			(MM/DD/YYYY) 9. I	Birthplace (State or eign
Director	Ì	191-48-2697 1 M 2XF 51	Yrs	Months Days	Hours Min.	8/29/1	956	Country) MD
any	-	Usual Residence of Decedent 10a, State 10b, County 10c, City	y, Town or Loca	ition				10d. Inside City Limits
<b>*</b> .			ean Pir	100				1 Yes 2 No
Maryland 28a-f show d at once,	황	10e. Street and Number	.cuii i ii	10f. Zip Code	_	10g	. Citizen of What C	ountry?
the Ma a or 2	Director	438 Ocean Parkway #39		21811			USA	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once	a a	11 Marital Status 12 Was Decedent Ever in L	J.S. 13. W	as Decedent of Hispa Yes, specify Cuban, I			14. Race - Am White, etc	nerican Indian, Black,
or ite	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	"			tioning ottory		
s after	<u>a</u> -	3 Widowed 4 X Divorced If Yes, Give Yaar or Dates:  15. Decedent's Education (Specify only highest grade completed)		Yes 2 X No		ork done	Specify: 16b. Kind of Busines	white ss/Industry
2 hour "nate Exar	ed-	Elementary/Secondary (0-12)  College (1-4 or 5+)		most of working life. D				
	Completed	12	N/A				N/A	
filed within If Hygiene ed other tha t, the Medic		17. Father's Name (First, Middle, Last)		1	3.Mother's Name		- ,	
ould be file Mental H marked c event, t	8	Francis Kirk	Table Maille	ng Address (Street	Margaret			nto Zin Codo)
은 Pis 등	유	19a. Informant's Name/Relationship (Type, Print)  Peggy Grinath / mother		Holly Swa				
l and 2 s Health au item 27	-		. Place of Dispo	osition (Name of ceme			20c. Location - City	
permit. Pages 1 ar Department of Her Important: If ite injury or other tr		1 Burial 2 X Cremation 3 Removal from State	crematory or o	other place) lopen Crem	7/3	81/2008	Frankfor	~d DF
iit. Pa irtmen ortani	+	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Name and Address				
Depr Imp inju	-	him Muchen	1	108 Willi				
hysician		23a. Part I. Enter the disease, or complications that caused the dear failure. List only one cause on each line.	th. Do not enter	the mode of dying, s	uch as cardiac or	respiratory arres	st, shock, or heart	Approximate Interv Between Onset ar
/Medical xaminer		Immediate Cause (Final disease a. Atherosclerot	ic card	liovascula	r diseas	se		Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Live birth	perME,	<b>, g882 8/1</b> Fetal death 3	2/08 TT	ncy	23d. Date of deli Month	very Day Year
ath ce attend or use	Sici	4 Pregnant at time of	death 5 (	Other (Specify)			1	
the de	Phy	Part II. Other significant conditions contributing to death but no	t resulting in the	e underlying cause gi	ven in Part I.	23e. Did tot	bacco use contribut	e to the cause of death?
s that gned b	2	Takin Gala oig.		, , , ,		1 Yes	2 No 3	Probably 4 🗸 Unknow
tal or Attending Physician: The law requires that the drs after death.  "I Director: After this certificate has been signed by the lifed in by the funeral director, page 2 should be detached	Completed					24a. Was a autops perform	sy prior	e autopsy findings availa to completion of cause o h? Yes 2 No
an: 1 ertific.	Be C	25. Was case referred to medical			of Death (Check	only one)		
hysici this c	To B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2	ER/Outpatie				Residence 6 🗸 C	Other: Scene
After funera		27. Manner of Death  1 Natural 5 Paneling (Month, Day, Year)	28b. Time o	· · · · · · · · · · · · · · · · · · ·	y at Work? es 2 No	28d. Describe h	low injury occurred	
death ctor:	atic	2 Accident Investigation				20f Leastine (C	treat and Number of	r Rural Route Number, C
pital or Attending Ph ours after death, teral Director: After t	Certification:	3 Suicide 6 Could not be determined (Specify)	nome, farm, st	reet, factory, office bi	uliding, etc.	or Town, St		r raiar route ramber, e
To the Hospital or Attent within 24 hours after feath To the Funeral Directors completely filled in by the	al Ce	29a. Certifier 1 Certifying Physician: To the best of my knowl	edge, death oc	curred at the time, da	te and place, and	due to the cause	e(s) and manner as	stated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or investig			at the time, date a		
F \$ F 5	ž	29b. Signature and title of certifier		29c. License			l	(Month, Day, Year)
		thenet & withall no		O.C.N	VI.⊑. 		July 29, 2008	
7		30. Name and A ress of person who completed cause of death (It		111 Penn Street	Raltimore N	AD 21201		
		Pamela E. Southall, MD Assistant Medical E  31. Date filed (Month, Day, Year) 32. Registrar's Sign			, Dailliole, I	VID 2 1201		
St Regist	ate trar	AUG 0 1 2008	I A	oseli				
/IH 17 Rev 1/2		1100	ORIGIN	IAL				
	1		J UII					

			For State Registrar		State of Ma	ai yiari	-	tificate of	neaith and it Death		Reg. No.	2008	25640
	Physici	an	1. Decedent's Name (First			~		· ·		2. Date of Dea Month July		2008 <sup>Year</sup>	3. Time of Death
20	/Medio	cal	Donald Anth		<del></del>	sr.		41 Ch T	L. C. D. W.	July	+	CUUO ounty of Death	8:50 PM
	Examir	er	4a. Facility Name (If not i. Dove House					Westmins			Car	rol1	
ļ,	Funeral Director		5. Social Security Numbe 368–30–8113 Usual Residence of Dece	1 🗓 1	/ 2		ast birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug /,	1932	9. Birth Cou Mich	nplace (State or Foreign intry) Legan
	land ow			County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	a-fsh	ctor	MD Ca	rroll		West	minste	er					1 □Yes 2 →No
	or 28	Dire	10e. Street and Number					10f. Zip Code		I	-	n of What Cou	intry?
	s 23a	sral	2819 Bird V					21157			USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 🂢 [	. ☐ Married	. Was Decedent I Armed Forces? 1 ∑Yes 2 ☐ N If Yes, Give Year or Dates:	No		Was Decedent of H f Yes, specify Cuba I □ Yes 2M No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		. Race - Amer Black, White pecify: Wh	
5-0	72 hc	etec	15. [ (Specify on	Decedent's Educa	tion completed)		(Give	lent's Usual Occup	durina most of work	ing I	16b. Kind	of Business/I	ndustry
121	within ene.	Completed by	Elementary/Secondary		College (1-4or 5	+)	life. L	oo NOT use retired cical Des	d) -		Dofor	sco Con	tractor
	filed Hygid	င်	17. Father's Name (First,	Middle, Last)	<u> </u>		Liecti	.icai Des	18. Mother's Name				cractor
<u>lan</u>	Aental Aental rked tic ev	To Be	Leo Budzins	ski					Martha I	ybowski			
, Maryland	and 2 shou salth and N 1 27 Is ma er trauma	33	19a. Informant's Name/P Michael W.				19b. Mailin 8726	g Address <i>(Street</i> Cardinal	and Number or Rui Forest C	al Route Numbe Circle L	aurel	own, State, Z	ip Code) 0723
Baltimore,	Pages 1 ament of He ant; If iten ury or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cre 4 □ Donation 5 □ 0	mation 3 ☐ Rei	moval from State			sition (Name of natory or other plac se Cremat	ory 07/2	Date 26/08		tion - City or T	
Balt	permit. Depart Import any Inj once.		21. Signature of Funeral	Vice (Qen, e	Sette	MO12			ss of Facility Crematic Heckrott				x 784 e MD 21029
			23a. Part 1. Enter the dis shock, or heart fail	ase, or complicative. List only one	tions that caused cause on each lir	the death	n. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.	Aden	<i>sce</i>	ween	enn C	2 hun	Steer	VI		Med
	Examiner	e.		b.	Due to (or as	PL	eurl	EShu	near	) (	5		Ino
	executed n and al-transit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Conus Due to (or as	ske	ure H	reeme !	Ruhur	٠			2ml
68760,	rificate be executed ng physician and as the burial-transit	Medical I		d.									
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent preg in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nan	t. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у	<u>.</u>	23	d. Date of deli Month	very Day Year
rds, P.	quires that to signed by all doe detact	þ	Part II. Other significant	conditions contr	buting to death bu	ut not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	_		the cause of death?
I Records,	: The law requir cate has been s page 2 should	Completed	•							24a. Was a autop perfor	sy	prior to c death?	opsy findings available ompletion of cause of
Vital	sician; T certificat rector, pa	Be (	25. Was case referred to examiner?						26. Place of Deat			HOSPIC	
of	Physi this c	<u>و</u>	1 Yes 2 No	Hos			ER/Outpatien		4 LI Nursing Ho			Other (Spec	in Dove Hour
	ling After une	tion		Pending investigation	28a. Date of Inju (Month, Da)	ry v, Year)	28b. Time of Injury	28c. Injur Work	y at <br Yes 2 □ No	28d. Describe h	ow injury o	occurred	
Division	Il or Attending after death. I Director: After d in by the fune	Certification:	2 Accident 3 Suicide 6 □ 4 Homicide	Could not be determined	28e. Place of Injubulding, etc.	ury - At ho c. <i>(Sp</i> ec <i>if</i> )	me, farm, stre		165 2 110	28f. Location (S City or Tow	Street and I vn, State)	Number or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in the	edical C	29a. Certifier (Check only one)	Certifying Physic Medical Examine	ian: To the best of the basis of and manner st	fexamina	wledge, death tion and/or in	occurred at the tire restigation, in my o	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title o	f certifier	///			29c. Licens	e number		29d. Date	signed (Month	, Day, Year)
	V 1 1			40	The			13	7949		Jul	254	haves
	10+1		30. Name and address of	person the com	pleted cause of d	eath (item	23a) (Type, I	Print)		F 4	(	)	2457
	E &	to.	31. Date filed (Month, Da	v, Year)	32. Registra	ar's Signat	ture A	in Olher	usther	e duk	205	عاله	etube, M
	Registr			L 2 8 201	J.	. معر	1 19	berte					

			For State	State of Ma		epartment of l			_	2000	05611
			State     Registrar  1. Decedent's Name (First, Middle, Las	rt)		Certificate of	Death	2. Date of Dea		2008	2554   3. Time of Death
	Physici /Medic		CAROLYN	WELCH E	BETTS			Month 07	20	2008	2:35A M
	Examir	ner	4a. Facility Name (If not institution, give				or Location of Deat	th		County of Death	
agit.	Females		Coastal Itospice 5. Social Security Number 6. S		(In yrs. last birth	day) If Under 1 Year	5 5 cm r g	8 Date of Birt	h	)i con,	place (State or Foreign
b	Funeral Director			□ M 2√ F	92 Y	Months Dave	Hours Min.		, Year) , 19	15 PEN	NSYLVANIA
	ow stand		10a. State 10b. County		10c. City, Town	or Location				1	10d. Inside City Limits
	Many a-fsh	ctor	MD WICOMIC	CO	SALISBU	RY					1  Yes 2□No
	a or 28	Il Director	10e. Street and Number 211 CREEKS	IDE DR.	-	10f. Zip Code 2180	)4		-	zen of What Cour	ntry?
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Emminer must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puer	Specify Yes or No- to Rican, etc.)		4. Race - Americ Black, White,  Specify: WHIT	etc.
5-0	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. D	ecedent's Usual Occu	pation	rkina	16b. Kin	nd of Business/In	dustry
121	/ithin /	mple	Elementary/Secondary (0-12)	College (1-4or 5+	)	Give kind of work done ife. DO NOT use retire	during most of wo	rking			
d 2	Hygie Hygie ther t		12 17. Father's Name (First, Middle, Last)	6	T.	EACHER	18 Mother's Na	me (First, Middle,		UCATION	
an	id be i lental ked o ic eve	To Be	WILBUR SHORT V	VELCH. SR.				McIlvai		ourname)	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (		19b. N	Mailing Address (Street	L			Town, State, Zip	Code)
Σ.	and 2 ealth a n 27 is		Marvin L. McIlva	ine	21	l Creekside	e Dr., Sa	lisbury,	MD	21804	
Baltimore,	Pages 1 lent of H nt: If iter ry or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State		hisposition (Name of crematory or other pla CREMATORY		Date -08		eation - City or To	wn, State
Balti	Departm Departm mporta Iny inju		21. Signature of Funeral Service Licen		Onition	22. Name and Addre	see of Facility	HORT FUN			ES
	202 400		23a. Part 1. Enter the disease, or comp	hou plications that caused t	he death Do no	416 FEDERA	AL ST., M	ILTON, D	E 19	968	
1	Physician /Medical Examiner		shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. METAS		COLON		•			Approximate Interval Between Onset and Death
	outed id ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	nonsequenne of)						
68760,	ificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a	consequence of)	:					
	To the Hospital or Attending Physician: The law requires that the death certifin to the hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		2	3d. Date of delive Month	ery Day Year
rds, P	quires that en signed t uld be dete	2	Part II. Other significant conditions of	ontributing to death but	not resulting in the	ne underlying cause giv	ven in Part I.	23e. Did to			he cause of death?
eco	sician: The law requir certificate has been s rector, page 2 should	Completed						24a. Was a		24b. Were auto	ppsy findings available
= =	Physician: The la r this certificate has ral director, page 2	Som						autop: perfor 1 □ Yes	med? 2.⊈ENo	death?	mpletion of cause of
Vita	iclan: certific ector,	Be	25. Was case referred to medical examiner?	11 2-1				ath (Check only or			
of	Physical this and direction	<u>و</u>	1 Yes 2 1No 27. Manner of Death		t 2 ER/Outp		4 LI Nursing F	lome 5 Resid			ý)
ion	ath. rr; After ne funer	ation	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day,		iry Wor	ryat k?  Yes 2∐No	28d. Describe h	ow injury	occurred	
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	, street, factory, office		28f. Location (S City or Tow	treet and n, State)	l Number or Rura	al Route Number,
	ne Hospi n 24 hour ne Funer	Medical	29a. Certifier (Check only one) Certifying Physics (Check only one)	ysician: To the best of liner: On the basis of and manner state	examination and/	death occurred at the to or investigation, in my	me, date and plac opinion, death occi	e, and due to the curred at the time, of	cause(s) date and	and manner as s place, and due to	stated. o the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
			20. Name and address of		W (1) = = = = = = = = = = = = = = = = = = =	1000	> 2410			7/20/0	Z
			30. Name and address of person who co	COA(TM	ain (Item 23a) (Ty	pe, Print)	110 17	77 CAU	(MII	all man	21907
	Sta	te	31. Date filed (Month, Day, Year)	completed cause of dea	's Signature	- 1- 1.	30/2 1/	15 21,00	الماويات	1 mi	-10-
	Registr	ar	AUG 0 8	S ZUUB	in li	Good					
DH	MH 17 Rev 1/20	001				*					

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			1 - For State Registrar	State	of Mary	land /		irtment of tificate o			Mental Hy	gier Reg. N		3 (	25642
	Physici /Medic	- 3	1. Decedent's Name (First, Middle Thomas Maxwel								2. Date of D Month July 2		2008	Year	3. Time of Death 7:56 A M
	Examin		4a. Facility Name (If not institution 7605 Arborvie		umber)			4b. City, Town 20622	, or Locati	on of Deat		,	c. County	les	
	Funeral Director		5. Social Security Number <b>579–64–3811</b>	6. Sex 1 <b>X</b> M 2□ F	7. Age (In	yrs. last b	oirthday) Yrs.	If Under 1 Year Months Day		der 24 Hrs. rs Min.	8. Date of B (Month, D	irth ay, Yea <b>y 1</b>	7,194	9. Birthi Coul <b>8 Wa</b>	place (State or Foreign ntry) shington, DC
	e Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Char	les	1	c. City, To Charle		Cation Ha11							0d. Inside City Limits 1 ☐ Yes 2 🏝 No
	h with th	Funeral Director	10e. Street and Number 7605 Arborview	Drive				10f. Zip Code 206:				-	Citizen of V	Vhat Cou	ntry?
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of health and Mental Hygiene. Depertment of health and Mental Hygiene. Important: if Item 27 is marked other than "nature", or Items 23a or 28a-f show amportant: if Item 27 is marked other than "nature", or Items 23a or 28a-f show amportant in inclined all appear.	þ	11. Marital Status  1 Never Married Married Married Midowed 4 Divorced	Armed I	2 No	in U.S.	l st	Vas Decedent of Yes, specify Co	ıban, Mex	ican, Puerl	pecify Yes or N to Rican, etc.)	0-	Blac	e - Americk, White,	
V-01212	d within 72 he giene. or then "natur	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 12	t grade completed	d) (1-4or 5+)		(Give )	lent's Usual Occ kind of work dor DO NOT use reti ronic C	ne during n red)		rking		Kind of Bu		rnment
	ild be file lenta! Hy ked oth	To Be C	17. Father's Name (First, Middle,  Jack Raymond								ne (First, Middle <b>Mills</b>	e, Maide	en Sumam	19)	
Mary	od 2 shot Ith and N 27 is mai		19a. Informant's Name/Relations  Donna Chaney/Wif					•			ral Route Numi				
oanumore,	Pages 1 ar ment of Hea ant: if item ury or other		20a. Method of Disposition  1 Burial 2 Cremation 4 Donation 5 Other (S			cemet	ery, crem 1and	sition (Name of natory or other p <b>Vetera</b>	ns Ce	em.	ıgüst 4. 2008	Che	Location -	ıam,	MD
Dal	permit. Depertimont import any inf		21. Signature of Funeral Service	cho II	I ME	00817					insfield Rd., Cl				, P.A. , MD 20622
	Cate be executed / Medical Examiner buyistion and the purial-transit the purial-transit	dicai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	o (or as a co	PTA PTA	• of): • of): • of):	to L	N	3	c or respiratory	arrest,			Approximate Interval Between Onset and Death
O. DOX O	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours either deeth.  within 24 hours either deeth.  To the Funeriel Director. After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		birth 2 🗀 gnant at time	Fetal deal		Ectopic pregnar Other (specify)					23d. Dat Mo	e of deliventh	ery Day Year
cords, r.	quires that I in signed by uld be deta	٥	Part II. Other significant condition	ons contributing to	death but no	ot resulting	in the un	nderlying cause	given in Pa	art I.			o use contr	ribute to t	he cause of death?
מו חפכט	n: The law re icate has bee r, page 2 sho	Completed									24a. Wa auto peri 1 Yes	s an opsy formed?	, 5	prior to co death?	opsy findings available impletion of cause of
5	ysician s certif directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	Inpatient	2 🗆 ER/O	Outnatient	t 3 DOA	thar.		ath <i>(Check only</i> Iome 5 <b>25</b> Res		6 □Oth	er (Snecii	(v)
	To the Hospital or Attending Physician: The law within 24 bours effectedeath.  To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2 to the funerel birector.	ation: T	27. Manner of Death  1 Salatural 5 Pendin 2 Accident investig	g 28a. Dat (Mo	e of Injury onth, Day Ye	28b	. Time of Injury	28c. In			28d. Describe				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	tal or Atters of bit of bit of bit of bit of bit of bit of the bit	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 200. Pid	ce of Injury - Iding, etc. (S	At home,	farm, stre	eet, factory, office	е		28f. Location City or To			er or Run	al Route Number,
	he Hospi in 24 hou he Funer pletely fill	edicai	29a. Certifier 1 Certifyir (Check only one) 1 Medical	g Physicien: To the Examiner On the and ma	he best of m basis of exa anner stated.	ımination a	ge, death and/or inv	estigation, in m	time, date opinion,	and place death occu	e, and due to the urred at the time	e cause , date a	(s) and ma ind place, a	nner as s and due t	tated. the cause(s)
-	To T To t	W	29b. Signature and title of certifie	ANO	D	1	M	29d Lice	nse numb	20	629	29d. [	Date signed	(Month,	S O B
1	8/0/1		Granze	who completed ca	WF	TT	(Type, F	Jaint) MY	).	WF	+LOi	S	Fi N	n ()	20603
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 2		Registrar's		X A	book							

DHMH 17 Rev 1/2001

Physiciar /Medica Examine
Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

**Physician** 🤰 /Medical Examiner

The law requires that the death certificate be executed burial-transit physician and the the attending n signed by the has Physician: After this funeral or Attending within 24 hours after death To the Funeral Director: filled in by

Division or Vital Records, P.O. Box 68760,

July 28 7:30 P M Tung Yung Choi 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 10227 Raleigh Tavern Lane Ellicott City Howard 8. Date of Birth (Month, Day, Year) Dec 10, 1916 If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Hours 1 □ M 2 🗙 F China Yrs 91 217 56 6671 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 United States 10227 Raleigh Tavern Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ₩ Widowed 4 Divorced Asian Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kam Woon Lau Jum Han Liu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8700 Manahan Drive Ellicott City, MD 21043 Samuel B. Choi/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Crest Lawn Mem. Gard. 8-2-2008 Marriottsville, MD 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 704AG 14 Due to (or state a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1☐ Yes 2█ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature ap little of certific 29c. License number 29d. Date signed (Month, Day, Year) July 29, 2008 2EC. 30. Name and address of person who cor pleted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

2 9 2008

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year MARK HAMILTON COX July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (St. Months | Days | Hours | Min. | April 26,1959 | Mary Land Social Security Number Sex XXM 2□ F 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** Yrs. Director 212-72-7450 49 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, Its Modical Examinating a Director Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 2537 Waterside Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2XXNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, be filed within 72 hours after ontal Hygiene.

d other than "natural", or ite Black, White, etc. 1 ∐Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 □Yes 2XXNo ş Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Cultural Resources 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H Stull Cox Shirley ဂ္ Donald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 Is a
any injury or other traus
once. Wendy Cox/Wife 2537 Wareside Drive, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/29/2008 Frederick, MD Stauffer Crematory 21. Sunature V Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Empolism disease or condition resulting in death) mongry Hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed Exami burial-trans Due to (or as a consequence of): physician the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 1 ☐ Yes 2 ☐ No 1 □Yes 2 K No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 2 After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Certification 28d. Describe how injury occurred 5 Pending investigation within 24 hours area co...

To the Funeral Director: Aff

To the Funeral Director: Aff 1 Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 103 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar 29b. Signature and title of certifi

31. Date filed (Month

Jarea

P.O. Box 68760.

Division of Vital Records,

801

29c. License number D43091

Toll House Ave

29d. Date signed (Month, Day, Year)

and manner stated.

MA

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar		State o	f Marylan		ırtmen <i>tificat</i>		ealth and N Death	Mental Hy	giene . No.	2008	25645
			Decedent's Name (First)	, Middle, Last)							2. Date of D			3. Time of Death
	Physicia	an	Earl C	Cox	oke,	Ir					July	Day 23		7:50 P M
	/Medic		4a. Facility Name (If not in:					4b. City.	Town, or	Location of Death			County of Death	
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			Homewood at 5. Social Security Number		nd ra	7. Age (In yrs.	last birthdav)	If Under		lerick If Under 24 Hrs.	8. Date of B	irth	Frederi 9. Bint	pplace (State or Foreign untry)
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			Usual Residence of Deced	dent		- 0.5			1		11000	, 1	, , , , , , , , , , , , , , , , , , ,	- y zuitu
	land		10a. State 10b.	County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
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	eeth	Funeral	11. Marital Status			edent Ever in U	.S. 13. \	Nas Dece		spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or N		14. Race - Ame	rican Indian,
	Iten	ä	1 Never Married 2		Armed Fo 1 ⊠Yes	orces?	1	f Yes, spe	city Cubar	n, Mexican, Puerto	Rican, etc.)	}	Black, White	
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and	od be	Be C	Earl C. Co	oke. Sr						Anna I	etcher			
Ξ	12 should be filed within a and Mental Hygiene. I le marked other then "I reumatic event, I'm Mental	2	19a. Informant's Name/Re				19b. Mailir	na Address	S (Street a	and Number or Ru		ber, City o	or Town, State, Z	Tip Code)
<u>8</u>	ages 1 and 2 should b nt of Health and Menis t: If item 27 le marked y or other traumatic e		Louise L. C					•						land 21702
a) D	1 and Healt		20a. Method of Disposition		ATIC	20b. F	Place of Dispo				Date		ocation - City or	
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Ē	men tant: jury		4 □Donation 5 □C			Fre	ederick				2008	Fred	lerick,	Maryland
Baltimore	permit. Pages 1 Department of H Important: If ite eny injury or ot once.		21. Signature of Fur erails	Service Licenses	1		16	2. Name a 521 0	nd Addres possi	ss of Facility Sta	uffer : Lke Fr	Funer ederi	al Home ck, Mar	s, P.A. yland 21702
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ś	igne bed		Part II. Other significant	_		bath but not res		)	4	eriti atti.				obably 4 Unknown
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á	or Attendiate after death.  Director: A in by the for	Certification;	4 Homicide		build	ding, etc. (Speci	Ty)				City or	Town, Stat	<del>u</del> /	
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	To the within 2 To the complet	Σ	29b. Signature and title d	certifier				29	c. Licens	e number		29d. Da	ate signed (Moni	u, Day, rear)
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	V		30. Name and addre	Darsan o cor	npleted car	use of death (Ite	т 23а) (Туре,	Print)		\ /			7	,
	J		Hiren S	nah, M	D. 1	5CT	homa	s To	hnso	in Dr f	red M	D 21	702	
	St	ate	31. Date filed (Month, Da	the second secon	2 32.	Regisyar's Sign	ature /	do	6					
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DHMH 17 Rev 1/2001

Known to Projections as: Cooke Earl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 6:00p 24 2008 Louise Ju<sub>1</sub>y Cavanaugh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 424 Pinoaks Place Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ ▼F 77 Months Davs Hours 229-84-5139 Jan. 11,1931 Director New Hampshire Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Place 21703 USA 424 Pinoaks Funeral 14. Race - American Indian, Black, White, etc. item 27 is marked other than "natural", or items other traumatic event, the Mecical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after Hygiene. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Textile Industry Dry Cleaner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cavanaugh Anna Goggin ၉ Η. James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) tem 27 is 12022 Harp Hill Road, Myersville, MD 21773 Dennis Tolland/Nephew Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages nent of I 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department of Important: If it any injury or o Stauffer Crematory 7/27/2008 Frederick, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 □Ectopic pregnancy The law requires that the death Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the at 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sl perform 1□ Yes 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of eath Check onl one Hospital: Other: 2No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 1 Tes Certification: To this 27. Mann of Death 28a. Date of Injury 28h. Time of 28c. 28d. Describe how injury occurred Injury at Work? (Month, Day 5 ☐ Pending investigation

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: After t 24 hours after death. the filled in by completely

2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signature

Medical

State

Registrar

4 Homicide

(Check only one)

31. Date filed (Month, Day,

within 24 To the I

and manner stated and title of certifier

6 ☐ Could not be

determined

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of perso who completed cause of death (item 23a) (Type, Print)

80

32. Registra s Signature 2008

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible lok, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens O O O Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** July 2008 George Richard Curran 10:00 a /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 ☐ F Yrs 78 Director 178-22-7681 Oct 05 1929 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 339 Hook Road 21157 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or ite, any injury or other treumatic event, the Medical Examinat 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ★o Specify: Specify: White ծ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dept of Agriculture 5+ Extension Agent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George Wesley Curran Mary Keener Danka Curran/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 339 Hook Road Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 07/2842008 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 K Removal from State New Harmony Presbyterian Cem Brogue, PA 4 □ Donation 5 □ Other (Specify) 22 Printer of Femeral Home and Chapel, P.A. 21. Signature of Funeral Service Licenses 412 Washington Road Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease 8+00 reri Physician disease or condition resulting in death) /Medical **Examiner** ixxhos' Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examiner use as the burial-transit death certificate be executed and Due to (or as a consequence of). Box 68760 the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pladder 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification; To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 24 hours after death. Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide filled in To the Hospitel of within 24 hours at To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MIL 30. Name and address of person who completed cause of death (Item 23%) (Type, Print) malasta DR, westminster, mo 2115) 3 349 PANSURIVE

Registrar

State

31. Date filed (Month, Day, Year)

ORIGINAL

Glown & Sperte

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 20<sup>ay</sup> 2008 7:25 A M **Physician** George E. Cooper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Caroline Caroline Hospice Home Denton If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. June 17 9. Birthplace (State or Foreign N. Carolin) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** <sup>Year)</sup>924 1**∑** M 2□ F 8 4 Yrs. June 243-28-3377 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County r 28a-f show 1 ☐ Yes 2 No Maryland Caroline Denton Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Medical Evaniner must be none. 21629 USA 401 South 8th Street Apt 401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1946 - 47 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8th 0 Cement Finisher Masonary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Goldie B. Cooper George H. Cooper ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Trappe, Md. 21673 3963 Harrison Circle John Coleman (Nephew) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-28-08 Hurlock Veteran Hurlock, Md. 4 ☐ Donation 5 ☐ Other (Specify) Minima Repaired of Scill Sons Mortuary, P.A. 21, Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Ceuse (Final Month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Lectopic pregnancy Month Day Year 5 Other (specify) signed by the a □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were eutopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed 2 No certificate 1 ☐ Yes r this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? nouse After Injury 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner d manner stated the

State Registrar

Halverson , MD <sup>Year)</sup> 5 31. Date filed (Month, Day, 2008

30. Name and address of person who completed cause of control (Item 23a) (Type, Print)

29b. Signature and title of certifier

Drive - Suite 302 Teal

29c. License number D66270 29d. Date signed (Month, Day, Year)

08-05989 Anthony Cłezobka Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 25649

		- For State	Cert	ificate of	Death		Reg.	No.	
Physicia		1 Decedent's Name (First, Middle,	Last)				2. Date of Death	Day Year	3. Time of Death
્રા Examin		ANTHONY J.C	IEZOBKA				Month E August 5, 20	008	1210 hrs
2		4a. Facility Name (if not institution,		4	b. City, Town, or Lo	cation of Death		4c. County of Deat	h
		Baltimore Washington I	Medical Center		Glen Burnie			Anne Arundel	
Funeral		5. Social Security Number 6	S. Sex 7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or Foreign
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2121 ould be fi Mental marked	2	19a. Informant's Name/Relationshi	ip (Type, Print ).	19b. Mailing	Address (Street	and Number or F	Rural Route Numb	er, City or Town, Stat	te, Zip Code)
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Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should	ertific		d not be 28e. Place of Injury - At ho	ome, farm, stre	et, factory, office bu	illaing, etc.	or Town, St		Adiai Madia Mambai, Oky
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Cer	4 Homicide	mined (Specify)						
To the Hos within 24 h To the Fur completely		29a. Certifier 1 Certifying Ph	nysician: To the best of my knowledgeminer: On the basis of examination a	ge, death occu	rred at the time, dat	te and place, and	d due to the cause	e(s) and manner as st and place, and due to	tated.
lo th	Medical		and manner stated.					29d. Date signed (M	
	Ž	29b. Signature and title of certifie	1		29c. License				
		Carol	Hallan		O.C.N	Λ.Ε.		August 6, 2008	3
		30. Name and address of person	who completed cause of death (Item						
		Carol Allan, MD Ass	sistant Medical Examiner	111 Penn	Street, Baltimo	ore, MD 2120	01		
	tate	0.136 7 7	32. Registrar's Signatu	ire	00				
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			Decedent's Name (First, Middle, I	Last)							2. Date of Dea	ath	000	3. Time of	
	Physicia /Medic			Betty Wi	ddoes C	ameron					Month August	3	2008	0235	$A^{M}$
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<i>,</i>			230 East Main S					kton		O.4 Lles			Cecil		
	Funeral Director		220-14-2381	.Sex 1 □ M 2 🛣 F	7. Age (In yrs. 82	Yrs.	Months	r 1 Year Days	Hours	Min.	8. Date of Birt (Month, Da April_6	y, Year)	Cot	place (State or intry) ryland	r Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside Cit	y Limits
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	er de:	Funeral	11. Marital Status	Armed F	cedent Ever in U forces? 2 X No	.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori ın, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White		
3	filed within 72 hours after death with the Maryland Hygiene. Hydiene. The Herns 23a or 28a-f show ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by F	1 □ Never Married 2 ሺ Married 3 □ Widowed 4 □ Divorced	If Yes, G	aive Dates:		1 🗌 Yes	2 <b>∏</b> No	Specify:			Sp	pecify:	hite	
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	should nd Me mark imatic	To.	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailii	ng Addres	s (Street a			al Route Numb	er, City or T	own, State, Z	ip Code)	
	alth a		J. Robert Camer	on/Husba	ınd	230	East	Main	Stre	et,	Elkton,	MD	21921		
5	of He fitem		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3	□ Removal from		Place of Dispo cemetery, cre	osition (Na matory or	me of other plac	e) A	ugus	t 4.	20c. Loca	tion - City or	owп, State	
	ment ment tant: I		4 ☐ Donation 5 ☐ Other (Spe	ecify)	R.	A. Ferri			nc. 2	800	,	We	st Che	ster, P	PA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In the m21s marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lie	censee		H	2. Name a icks	nd Addres Home	ss of Facilit	y Fune	rals, Feet, El	P.A.			
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that	caused the deat	h. Do not en	03_W. ter the mo	_Sto	ckton	_Str	eet, El	kton,	MD 2	1921 Approximate	<del></del>
	Physician		Immediate Cause (Final	nly one cause on	each line.	1		- ,						Onset and D	ween Death
	/Medical		disease or condition resulting in death)	a. Due to	o (or as a conseq	juence of):	Fa	1 1 26	NE						
	Examiner		Sequentially list conditions	b. De	2 hydr	ation	n								
,	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conseq	uence of):	1 0	1.							
	and al-tran	xan	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	uence of):	146	101	ma						
3	ate be executed hysician and the burial-transit	ical E		4			•								
5	g physi as the I			u.											
5	death certifica attending ph	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna		⊒Ectopic p	геппапсу	,			230	d. Date of deli		
י נ	e deal	sicia	in the past 12 months? 1 ☐ Yes 2 M No		gnant at time of c		Other (s						Month	Day Y	/ear
•	w requires that the de been signed by the a should be detached	Phy	9 ☐ Unknown  Part II. Other significant condition	s contributing to	death but not res	ulting in the u	ınderivina	rause nive	en in Part I		23e. Did t	obacco use	contribute to	the cause of d	eath?
, S	signe d be d	d by		e continue migra				3						obably 4 🚉 U	
5	w req	Completed									24a. Was	an	24b. Were au	topsy findings a	available
ב	The lav te has age 2 :	omo										psy ormed?	prior to death? 1 ☐ Yes	ompletion of ca 2 X No	ause of
2	lan: rtifical	Be C	25. Was case referred to medical						26. Place	e of Deatl	1 Yes 1 (Check only o	2 No No	T Tes	2,24,110	
>	Physician: The la	To E	examiner? 1 ☐ Yes 2 🔼 No			ER/Outpatie			4 LI NU	ursing Ho	me 5 <b>K</b> Resi	dence 6 [	□Other (Spec	ify)	-
	ding P		27. Manner of Death 1   Natural 5 □ Pending	(Mo	e of Injury onth, Day Year)	28b. Time o		28c. Injur Worl			28d. Describe	how injury o	occurred		
2	death ctor: / the f	icati	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be	ce of injury - At h	ome, farm, st	M reet_factor		Yes 2		28f. Location (	Street and I	Number or Ru	ral Route Num	her.
3	after after Direct	Certification:	4 ☐ Homicide determin	ed buil	ding, etc. (Speci	fy)		,,			City or To				201,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			Physician: To the											
	the Ho iin 24 the Fu	Medical	one)	xaminer: On the and ma	nner stated.	auon and/or ir				ath occur	red at the time,				·) 
	Mit Fig.	2	29b. Signature and title of certifier	91.	MN	}	29	Λ.	e number	-	, ,	29d. Date :	signed (Monti	n, Day, Year)	0
)	2		July 12	Mu .	V V	m 09c\ /*	Dwi-4\	V U	06	50	15	0	/ 7/	200	0
	7		30. Name and address of person w	no completed car				+	n V	71	7.1	921			
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Signa				. ,	- / -		, - 1			
	Panietr		0 CLO 0 0 001	20 4	3	All I	45								

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State

BRENDON

31. Date filed (Month

MO

CAMBREDGE

AURORA

Registrar's Signaty

			Please			Indelible Ink		_	_	
			For State Registrar		•	epartment of I Certificate of		_	iene	25652
	Physici /Medic		1. Decedent's Name (First, Middle, Las John Leonard DeMa	rr				2. Date of Deat Month July 24	Day Year	32 molof Deau 2
	Examin Funeral Director	er	214-30-3933	d	(In yrs. last birti	Aquasco	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/30/1	Year) Cou	
	Maryland I-f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince Go		10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 22601 Aquasco Road		nquases	10f. Zip Code 20608			0g. Citizen of What Cou	untry?
2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Exammed Forces? 11√√Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
0-6171	vithin 72 ho ne. han "natul e Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Sistant Pos	during most of work d)	ing	16b. Kind of Business/I	ŕ
	ild be filed within lental Hygiene. ked other than " Ic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) Jerome DeMarr		ASS	SISLANL POS	18. Mother's Nam Emily R	e (First, Middle, N	U.S. Posta Maiden Surname)	l_Service
	and 2 should ealth and Men n 27 is marke ner traumatic		19a. Informant's Name/Relationship (7		P.	Mailing Address (Street  O. Box #3,	and Number or Rui	ral Route Number	, City or Town, State, Z	ip Code)
Danilliore	it. Pages 1 intment of H intant: If itel njury or ott		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify  21. Signal are of Juneral Service Licen	)	cemeter	Disposition (Name of y, crematory or other plate: Family Plate	ot 07/2	9/2008	Aquasco, MI	)
Ö O	permit. Departn Importa any Inji		23a. Part1. Enter the disease, or comp	lliung	M01436	B035 01d Wa	<u>ashington</u>	<u>Rd., Wa</u>		nc. 20601 Approximate
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	cleroti consequence o		cular Dis	ease		Interval Between Onset and Death
, 00/00,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Exa	resulting in death) Last	C. Due to (or as a .d	· 	f):				
.O. DOX	t the death or the by the atten ached for us	hysician	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deline Month	very Day Year
colds, r	requires tha sen signed ould be det	ρ	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause giv	ven in Part I.		es 2 No 3 Pro	
ומו ושנו	n: The law ificate has bur, page 2 sh	Completed	OF War and the state of the sta						y prior to c ned? death? 2 ☑ No 1 ☐ Yes	topsy findings available ompletion of cause of
>	nysicia nis certi directo	To Be	25. Was case referred to medical examiner?  1 ☒ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2   ER/Out	patient 3 DOA Oth	26. Place of Deat ner: 4 ☐ Nursing Ho		e) ence 6 □Other (Spec	ify)
	To the hospital or Attending Physician: The lay within 24 hours after death within 24 hours after death and to the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death  1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide  2 ☐ Could not be	28a. Date of Injury (Month, Day	Yea <i>r)</i> In	jury Woi M 1□		28d. Describe ho	w injury occurred	
2	spital or At ours after o neral Direc filled in by		4 Homicide determined	building, etc.	(Specify)	m, street, factory, office	me, date and place	City or Town		
;	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical	(Check only one)  2 Medical Example one)  29b. Signature and title of certifier	and manner state	examination and	/or investigation, in my	opinion, death occur	red at the time, d	ate and place, and due	to the cause(s)
	w var.2m		30. Name and address of person who do	completed cause of dea	125	D0007  Type, Print)	967	J	uly 25, 20	08
D	Sta	te.	Albert E. Rolle, 31. Date filed (Month, Day, Year)	M.D. 600	Riverbe s Signature	nd Road, Ft	. Washing	ton, MD	20744	
2.00	Registr		JÚL 2 9	2008 32. Registrar	u B	Sparke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Elizabeth Erholm 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Days 220-12-1867 1 □ M 2 🕱 F 81 7/7/1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Wicomico Maryland Eden 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21822 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ XNo Specify: Specify white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) housewife Domestic 18. Mother's Name (First, Middle, Maiden Surname) Nancy Katherine Downs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1656 Laurel Lane, Macungie, PA 18062 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Salisbury Crematory 7/25/08 Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association Domoso CFSP 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death a. CORONAY NEEDY YORS Due to (or as a consequence of Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CMETO PRETERY 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □ Yes 2 PNO 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

o Vital ð

33

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

death with the Maryland r than "natural", or items 23a or 28a-f show the Modical Experience by notified at Director 10e. Street and Number 5165 Cooper Road Funeral 11. Marital Status fited within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ģ 3 Widowed 4 Divorced Completed Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, Ite IV Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be James Kendall Fitzgerald ပ္ 19a. Informant's Name/Relationship (Type. Print) Sharon Lynn Colson/daughter permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. 3altimore. 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee avil H. 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or mortyling Cause (Disease or injury Examiner requires that the death certificate be executed for use as the burial-transi resulting in death) Last physician Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No detached is been signed by the 2 should be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by The law this certificate has page 2 : After this certifica e funeral director, p or Attending Physician: 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a, Certifier 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D53551 5/100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carrou JAMES 100 E. ST. JAUSBURY Md. 10DD State JUL 28 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last)

#### 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day CYNTHIA ARLENE FENWICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death પેc. County of Death Examiner CENTER ar If Under 24 Hrs. NVISTA MEDICAL 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√□ F Months Days Hours Min Yrs. Director 213-82-8745 41 AUG 16. 1966 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, ibs Medical Examinar must be notified at Director MD CHARLES WALDORF 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3008 GALLERY PLACE, APT T7 20602 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN MEDICAL permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie important; if item 27 is marked other any injury or other traumatic event, the ENWICK, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN WALTER DADE ပ PEARL LILLIE FOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN FENWICK/BROTHER 300 GARNER AVENUE, WALDORF, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation PETER'S CH CEM 4 ☐ Donation 5 ☐ Other (Specify) 8/2/2008 WALDORF, MARYLAND 21. Signature of Funeral Service Transee LYDIA C. THORNTON JOHNSON MOSS 722. Name and Address of Facility THORNTON FUNERAL HOME, 3439 LIVINGSTON ROAD, 'INDIAN HEAD, MD 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on euch line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a Examiner Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p as IF FFMALE ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) the 1 ☐Yes 2 No 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No page 2 should Completed 24a. Was an has autopsy certificate 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 250 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral di Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in I 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Year

A M

05

9. Birthplace (State or Foreign

10d. Inside City Limits

20640

Approximate Interval Between Onset and Death

Month

Dav

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

N Yes 2 □ No

MARYLAND

BLACK

State Registrar

completely

within 2

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certified

39 Name and address of perso

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

wno completed cause of death (Item 23a) (Type, Print

32. Reatstrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

			For State Registrar	ate of Maryland / De	partment of Health ertificate of Deal	h and Mei th	ntal Hygie		25656
			Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death
п	Physicia /Medic		Norwood M. Fisher	•		J	Month ulv 2	Day Year 0 2008	7:00 P M
	Examin		4a. Facility Name (If not institution, give stree		4b. City, Town, or Location			4c. County of Dea	
П			Corsica Hills		Centrevi1	le.		Queen A	nne's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Months Days Hou	ider 24 Hrs. 8.	Date of Birth (Month, Day, Ye	Q Ri	thplace (State or Foreign ountry)
	Director	ļ	220-28-1821 <sup>1</sup> X <sup>M</sup>	86 Yrs		J	an 9 1		ryĺand
	and	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Aaryti sho	5	Maryland Queen Ann		sonville				1 ☐ Yes 2 ☑ No
	28a-	ect	10e. Street and Number		10f. Zip Code		100	. Citizen of What C	ountov?
	3a or	₫	4 Grasonville Ter	race	21638			USA	
	Jeath The 20	Funeral Director	11. Marital Status 12. V	Vas Decedent Ever in U.S. 1	3. Was Decedent of Hispanic	Origin? (Specif	y Yes or No-	14. Race - Am	erican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any fujury or other traumatic event, the Medical Examinant in until the midified at ODCe.	by Fur	Never Married 2 Married	nmed Forces? ☐Yes 2[XNo iYes, Give fear or Dates:	If Yes, specify Cuban, Mexi 1 ☐ Yes 2X1 No Spec	rican, Puerto Ric	án, etc.)	Specify: B	te, etc. 1ack
21215-003	2 hou	Completed	15. Decedent's Educatio		cedent's Usual Occupation		166	b. Kind of Business	/Industry
215	hin 7	ple	(Specify only highest grade cor Elementary/Secondary (0-12)	npieted) (G life College (1-4or 5+)	ive kind of work done during n a. DO NOT use retired)	most of working			
2	od wit	Ö	7th		klift Opera	tor	F	riels S	E W
2	al Hy al Hy al oth	Be (	17. Father's Name (First, Middle, Last)				irst, Middle, Mai	den Sumame)	
Maryland	Ment Ment arked	70	John W. Fisher		I	sabell	a McBr	ide	
<u>a</u>	2 sh and is m	- %	19a. Informant's Name/Relationship (Type, F		ailing Address (Street and Nur			-	
	and tealth om 27 ther t		Caroline Newman(I		Forest Rd.	Graso			
altimore,	t of the state of		20a. Method of Disposition 1	val from State cemetery, o	rematory or other place)	l		c. Location - City o	
┋	it. Partimer rtant rtant		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Spring		7-29-		enton,	
Ba	Depa Impo		Jarry D, Rean		Windows Reverse of & 821 West St	. Anna	polis,	Md. 21	
			23a. Part1. Enter the disease, of complication shock, or heart failure. List only one care	luse on each line.			,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Esophageel co	ucmoma, me	tastatic	to/iver	,	Months
	/Medical Examiner		resulting in death)	Due to for as a sinsequence of):					
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	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):					
•	xecul and al-trar	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence of):					
8760,	ficate be executed physicien and s the burial-transit								
687	ificate g phy as the	edicai	0						
ŏ	n cert	Z M	IF FEMALE: 23b. Was decedent pregnant 23c. I	yes, outcome of pregnancy	- 7-			23d. Date of de	elivery
P.O. Box	death e atte	Physician/M	in the past 12 months?	Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (s <i>pecify</i> )			Month	Day Year
Ö	at the by th	hys	9 Li Onknown	9□ Unknown					
	quires than signed and be de	by	Part II. Other significant conditions contributions of the A/z hermer's		e underlying cause given in Pa	art I.	23e. Did tobac 1 ☐ Yes		o the cause of death? robably 4 Dunknown
00	s bee	Completed				1	24a. Was an	24b. Were a	utopsy findings available
æ	The Is te he	щo					autopsy	prior to d2 death?	completion of cause of
a	an: rtifice tor, p	4	25. Was case referred to medical		26. Pi	Place of Death (C	1 □ Yes 2 ⊠	1019	s 2□No
>	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No Hospi	tal: 1 ☐ Inpatient 2 ☐ ER/Outpa				e 6 □Other (Sp	ecify)
Division of Vital Records,	Attending Physician: The law requires that the death certifudeath. If death. Sector: After this certificete hes been signed by the attending by the funeral director, page 2 should be detached for use as	ation:	27. Manner of Death 2:  1 Natural 5 Pending 2 Accident investigation	Ba. Date of Injury (Month, Day Year) 28b. Tim Injur	of 28c. Injury at	280	d. Describe how		
Divis	ai or Atte i efter de: i Directo d in by th	Certification;	3 Suicide 6 Could not be determined	Be. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f	Location (Stree City or Town, S		lural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours effer death. To the Funeral Director: After this certificate hes been signed by the attending gempletely filled in by the funeral director, page 2 should be delached for use as	edicai C	(Check only 2 Medical Examiner:	n: To the best of my knowledge, d On the basis of examination and/o and manner stated.	eath secured at the time, date r investigation, in my opinion,	a and place, and death occurred	due to the caus at the time, date	and place, and du	e to the cause(s)
	within To th	Me	29b. Signature and title of certifier	7 / 1	29c. License numb	ber	29d.	Date signed (Mor	ith, Day, Year)
)	al		MARKE	av/ey M)	PZS	933		7.24	,08
	1/2	0	30. Name and address of person who completed the complete of t	eted cause of death (Item 23a) (Ty	pans Lone, E	aston.	MD Z	1601	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	, , ,		-		
		ar	JUL 2 5 2008	Some &					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 23, 2008 12:20 P.M Leonard **FRANK** 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Rockville Rockville Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 18, 19720 5. Social Security Number 6 Sav 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Philadelphia, PA 1 ¥ M 2 □ F 87 149-05-4212 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? U.S.A. 20850 703 Gaither Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Lighting Warehouse Sales 18. Mother's Name (First, Middle, Maiden Surname)
Cecelia Platt 17. Father's Name (First, Middle, Last) Alexander Frank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Gaither Rd., Rockville, MD 20850 Steven Frank / son 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Roosevelt Cemetery 07/27/08 Trevose, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral School Ocense 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ayguant Marina Due to (or as a consequence of): Cilorovascul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Iniun 2 Accident

Physician /Medical Examiner The law requires that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760 the

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Examiner

Be

Certification: To

Medical

State

Registrar

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at

permit. Page Department of Important: If any injury or

Baltimore, Maryland 21215-0036

attending use for page 2 s director, After this funeral death. 24 hours after death e Funeral Director: filled in by

the the To the within 7

Hospital or Attending Physiclan:

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) and manner stated.

6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

KOCKVILLE.

29b. Signature and title of certifier JOSUPI worms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STON

1330 DOU Thomas V. Joseph, MD

207.

Location (Street and Number or Rural Route Number, City or Town, State)

EDMON 31. Date filed (Month, Day, Year)

3 ☐ Suicide

4 ☐ Homicide

25

Registrar's Signature

DR -

SUITE

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ames Livis i e		1- For State Certificate of Registrar Certificate of		Reg. No		8 2565					
Physici Nedical Exam		1. Decedent's Name (First, Middle,Last)  James Elvis Fenwick		2. Date of Death Month Day July 8, 2008		3. Time of Death 0135 hrs					
			Hb. City, Town, or Location of De Lexington Park		4c. County of Death St. Mary's	F.					
Funeral Director	4	5. Social Security Number         6. Sex         7. Age (in yrs. last birthday)           220-78-4981         1 X M 2 F         44 Yrs		Hrs. 8. Date of Birth (MI Min. May 25,	M/DD/YYYY) 9. Birth Foreign Cou						
ow any.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati				10d. Inside City Limits  1 Yes 2 X No					
th the Maryland 23a or 28a-f sho	ctor	Maryland St. Mary's Lexingto	n Park I 10f. Zip Code	10g. C	citizen of What Coun						
the Ma	Director	46568 Valley Court Apt. 2019	20653		USA						
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. ten 27 is made other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	Funeral		s Decedent of Hispanic Origin? ( es, specify Cuban, Mexican, Pue		14. Race - Americ White, etc.	an Indian, Black,					
after crall, or	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:			ack					
136 thin 72 hours te. than "natur:			t's Usual Occupation (Give kind ost of working life. DO NOT use		. Kind of Business/Ir	ndustry					
036 ithin 7. re. r than	Completed	10 Disabl	.ed	D	isabled						
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)		ame (First, Middle, Maide	,						
212. uld be Mental marke	To Be	James Andrew Fenwick  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing	Address (Street and Number	atherine Yo or Rural Route Number.		Zip Code)					
MD 2 d 2 shoul lth and N n 27 is m		Mary Catherine Fenwick / Mother 20551 7	free Top Road, Lexi		•						
of F.		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition or other states are crematory or other states.	ition (Name of cemetery, ner place)	Date 200 11y 24,	c. Location - City or	Town, State					
- <del>-</del>	per .	4 Donation 5 Other Specify: St. Peter C	laver Cemetery	2008 S	t. Inigoes,	Maryland					
Balt permit. Departi Import			lame and Address of Facility Ma D. Box 270, Leonard			Home, P.A.					
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.			Approximate Interval Between Onset and						
/Medical xaminer		Immediate Cause (Final disease a Cocaine use complicat	lure	Death							
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.									
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
i i	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Due to (or as a consequence of):								
xecuter n and - trans	calE	d.  XUNPENDED AMENDED 23aPII,27,peri	Œ. 0882 8/12/N	8 TT							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	<u>.</u>					
687 ertifica ding pl	ian/N	23b. Was decedent pregnant in the past 12 months?	tal death 3 Ectopic pre			ay Year					
Box 687  death certific  the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 0 Ot	her (Specify)								
that the d		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobaco	co use contribute to f	he cause of death?					
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the research death.  The Intercort After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed by	renal disease		_ 1Yes 2		ably 4 🗹 Unknown					
cords, law requir has been s	plet		<del></del>	24a. Was an autopsy performed	prior to o	opsy findings available ompletion of cause of					
tal Rection: The certificate ector, page				1 Yes 2		s 2 No					
Vital Rec ysician: The his certificate director, page	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Che	rsing Home 5 Resi	idence 6 🗸 Other	: Scene					
of \ng Phy	-	27. Manner of Death 28a. Date of Injury 28b. Time of it		28d. Describe how i							
sion ttendi death. ctor: ,	atio	Pending  Accident Investigation	1 Yes 2 No								
Divis	Certification:	3 Suicide 6 Could not be determined (Specify)	et, factory, office building, etc.	28f. Location (Stree or Town, State)		ral Route Number, City					
Division of <sup>1</sup> To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral		4 Homicide (Specify)  29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occur	red at the time, date and place,	and due to the cause(s)	and manner as state	ed.					
Fo the vithin 2 Fo the omplet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.									
L % F S	ž	29b. Signature and title of certifier	29c. License number		d. Date signed (Mor	nth, Day, Year)					
		but Teg NP	O.C.M.E.	Ju	uly 8, 2008						
		30. Name and address of person ₩n∂ completed cause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111	Penn Street, Baltimore,	MD 21201							
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature									
Regis	trar	AUG 1 1 2008 Bones & April	ASK.								

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar 25659 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Charles Francis Ju1y 24, Graham 2008 6:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □XM 2 □ F Director 214-28-5258 79 April 5, 1929 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examinar , ust be notified at Funeral Director 1 XYes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1203 Matthews Drive 20851 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: White Completed by 3 Widowed 4 Divorced Korea the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heavy Equipment at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Movers Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Edward ဂ္ Graham Mary Elizabeth Mann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Harding Graham - Wife 1203 Matthews Drive, Rockville, Maryland 20851 permit. Pages 1
Department of H
Important: If iter
any Injury or ott 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 7/28/08 Silver Spring, Maryland 4 ☐ Dopation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home illiams howert L. 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) Electrolyte Imbalance 3 Days /Medical Due to (or as a consequence of): **Examiner** Renal Insufficiency 3 Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offi-The law requires that the death certificate be executed Sepsis Due to (or as a consequence of): the attending physician and for use as the burial Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of deliven 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Protein Calorie Malnutrition 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □Yes 2 🖾 No Pneumonia 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐Yes 2 ☐No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 🛣 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 XNatural 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37891 July 25, 2008 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121 Congressional Lane - #409, A. Rajvanshi M.D.Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Regist State 8 2008 Registrar

DHMH 17 Rev 1/2001

1/24/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 **Physician** July Glenn Thomas Gincley 2008 2:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 **№** M 2 🗆 F 60 Pennsylvania Dec 8, Director 1947 194-38-8776 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Maryland Frederick Middletown 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21769 7313 Coventry Drive filed within 72 hours after death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 **▼**Yes 2 If Yes, Give 2 □ No 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: \$ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It a Many Injury or other traumatic event, Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Manager - Data Base Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Yatsko Earl Gincley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21769 7313 Coventry Drive, Middletown, Maryland Leslie Gincley - wife Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Christ Reformed 7-30-2008 Middletown, Maryland 4 Donation 5 Dother (Specify) 21. Sign aure of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 Caron Carmille Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Septic Physician OURS disease or condition resulting in death) /Medical Due to (or as a consequence of): of the Gallblodder Examiner Adenocascinoma Sequentially list conditions, if any, leading to infiltediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as signed by the attending I be detached for use as IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been a al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 210No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physiclan: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation e Hospital or Attendii 24 hours after death. e Funeral Director: A letely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 24/08

Registrar DHMH 17 Rev 1/2001

State

medesick

S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

28

Tanen

31. Date filed (Month, Day, Year)

MD 51610

Amended Item 19a per F.D. 07/30/2008 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 24, July 2008 11:35 Dorothea Louise Godwin /Medical 4a. Facility Name (If not institution, give street and number)
Carroll Hospital Center 4b. City, Town, or Location of Death Westminster 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New Castle, PA Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2₩F 217-20-3717 82 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show mix: If Item 27 is marked other than "natural", or items 25a or 28a-f show my or other traumatic event, the Medical Examiner must be notitled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ∏Yes 2X No Director MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4418 Black Rock Road Apt. #7 21074 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Jones Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shiringy's Nyme/Propsic Type Daughter Shirley J. Probst Daughter-690 Arbor Drive, Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremations 7/26/2008 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. 21. Signature of Funeral Service Licensee agel 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 14 V /Medical Due to (or as a consequence of): Ordro voscilled disease Examiner 142 thous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, q 1 Tyes 2 No 3 Probably 4 Wiknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes certificate 217No Division or Vital To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

WJL 5+5

Stoner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

			For State Registrar	State o	f Maryla	nd / Depa <i>Ce</i>			lealth Death		_	giene Reg. No	2000	3 256	6
	Physici	an	1. Decedent's Name (First, Middle	Last)							2. Date of De			3. Time of Dea	
	/Medic	cal			aw						Ju1y	21,	2008	9:15 P	M
	Examir	ier	4a. Facility Name (If not institution, Kensington Park		,				r Location ng ton				. County of Deat [ontgome		
	Funeral			6. Sex		s. last birthday)		r 1 Year	if Under		8. Date of Bir			hplace (State or Fo untry) lington,	reign
	Director		579-24-9326	1 □ M 2 🖾 F	8:	2 Yrs.	Months	Days	Hours	MIII.	March	10,1	926 Wash	ington,	DC
	fand		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City L	imits
	Mary a-f sho	tor	Maryland Montgo	mery	Ga	ithersb	urg							1 □ Yes 2	No 2
	or 28%	Director	10e. Street and Number		I		10f. Zi	p Code				10g. Cit	izen of What Co	untry?	
	ath w		7 Duvall Lane					0877					ted Sta		
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. i marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 Tes if Yes, Giv Year or De	rces? 2 <b>☑</b> No ⁄e		Was Dece if Yes, sp∈ 1 □ Yes	ecify Cuba	ispanic Or an, Mexica Specify.	in, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Biack, White Specify: Wh		
9	2 hou latura Ical E	ted	15. Decedent	s Education		16a. Dece	dent's Usi	ual Occup	ation			16b. K	ind of Business/		
218	ithin 7 ne. nan "r Med	nple	(Specify only highes: Elementary/Secondary (0-12)	College (1	-4or 5+)	Give life. Chi Intel	RING OF W DO NOT ( ef o	ork done d ise retired f Foi	auring mos reien	st of worki	ng	Fed	eral Governm	ent	
22	iled w lygier ther th	Be Completed	17. Father's Name (First, Middle, L	4		Intel	lige	nce I			(First, Middle	Maiden			
and	should be filed nd Mental Hygi marked other imatic event, <u>t</u>	To Be	Walter Francis	,				1			e Van D	,	/		
Maryland 21215-0036	shou and M s mar	۲	19a. Informant's Name/Relationsh			19b. Maili	ng Addres	s (Street					or Town, State, Z	ip Code)	
Σ,	and 2 ealth a m 27 i		Peter D. Gaw	(Son)									Texas		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev once.		20a. Method of Disposition 1   Burial 2 □ Cremation			Place of Dispo	sition (Na Patery or Hea	me of otber plac	(e)	July	26,	20c. Lo	ocation - City or	Town, State	
<u>=</u>	artmer artmer ortant: injury		4 □ Donation 5 □ Other (Sp 21. Signature □ o eral Se7 □ L	ecify)		Ceme		nd Addres	ss of Facili	200	8   Vol Fui		ver Spri	.ng, MD	-
Ra	Department and any once		Wir #X											MD 2087	7
	Physician /Medical Examiner	ler	23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. A1 Due to (		r's Dis		de of dyin	g, such as	s cardiac o	r respiratory a	rrest,		Approximate Interval Betwee Onset and Dear Years	n h
08/00,	death certificate be executed e attending physician and d for use as the burial-transit	edical Examiner	cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conse	quence of):									
.C. BOX		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		irth 2□Fet ant at time of	tal death 3□	]Ectopic p ] Other (s						23d. Date of deli Month	very Day Year	,
1	g g j	by Pt	Part il. Other significant condition	ns contributing to de	eath but not re	sulting in the u	nderlying	cause give	en in Part I	l.	23e. Did t	obacco u	se contribute to	the cause of death	1?
ecords,	w requires to be signer as should be	ted t	Hypertension								1 🗆	Yes 2	No 3□Pro	obably 4 □Unkr	nown
ပ္တိ		Completed	<u>Hyperlipidemia</u>								24a. Was	psy	24b. Were au	topsy findings avai ompletion of cause	lable
VITal K	<b>sician:</b> The law certificate has b rector, page 2 s		Breast Cancer								perfo 1□ Yes	rmed? 2 XNo	death?	2□ No	
	Physician: this certificatel director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nnationt 2F	☐ ER/Outpatier		Othe	DF:		(Check only o				
10	g Phys er this eral dii	$\vdash$	27. Manner of Death	28a. Date		28b. Time o		28c. Injun Work	4.6C. INI		ne 5 ∐ Resi 28d. Describe		6 □Other (Spec y occurred	aify)	
SIOL	ttending Fleath. tor: After the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	ition	n, Day rear)	Injury	М		Yes 2□	No					
DIVISION	the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 20e. Place buildii	ng, etc. (Spec						City or To	vn, State	)	ral Route Number,	
	ne Hosp 24 hou ne Fune detely fil	Medical	29a. Certifier 1X Certifying (Check only one) 2  Medical E	Physician: To the xaminer: On the ba and manr	asis of examin	owledge, deatl ation and/or in	occurred vestigation	at the tin n, in my o	ne, date ai pinion, de	nd place, a ath occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within 24	Me	29b. Signature and title of certifier	1	$\cap$		29	c. License	number			29d. Da	te signed (Month	a, Day, Year)	
)	15		ruward 1					26607	7			Ju1y	22, 20	08	
			30. Name and address of person w Edward T. Culle	n, MD 76	e of death (Ite	m 23a) (Type, consin	Print) Ave.	#10	1 Bet	hesd	a. MD 2	081/			
	Sta	_	31. Date filed (Month, Day, Year)	32 R	egistrar's Sign	nature	-2	20			., 2				
	Registr	ar	HH 9 Q 3	TITO Es		60 100									

DHMH 17 Rev 1/2001

		For State Registrar	State	of Marylai	nd / Depa	artment of rtificate of	Health a	and Mental F	lygiene Reg. No.	0000	25663
Physici /Medic		1. Decedent's Name (First, Midde Margaret L.	lle, Last) Giersz	ewski				2. Date of Month July	Death	2008 <sup>Year</sup>	3. Time of Death 11:34 A M
Examir		4a. Facility Name (If not instituted Suburban Hosp	ital			4b. City, Town, Bethes	da		M	County of Death	
Funeral Director		5. Social Security Number 486-16-9388 Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs		If Under 1 Year Months Days		Min. Jan.8	Birth Day, Year) 10, 191	9. Birthp Coul MO	place (State or Foreign ntry)
Maryland a-f show	ctor	10a. State 10b. County  MD Montg			ity, Town or Lo					1	10d. Inside City Limits 1 XYes 2 No
h with the 23a or 28 st be not	al Dire	10e. Street and Number 6 Grason Court				10f. Zip Code	20850			zen of What Cour ed State	*
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Midical Evar, i'm in ual be neithed at once.	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ※ Ma 3 ☐ Widowed 4 ☐ Divorce	rried Armed F	3 2 Mario Give		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		gin? (Specify Yes or i, Puerto Rican, etc.)		14. Race - Ameri Black, White, Specify: White	etc.
ed within 72 h ygiene. er than "natu	Completed	(Specify only high Elementary/Secondary (0-12)		(1-4or 5+)	(Give	dent's Usual Occi kind of work doni DO NOT use retir	e during most ed)		NI		dustry
y carry ould be file Mental Hi larked oth	To Be	17. Father's Name (First, Middle Theodore Meine	rshagen				Ade1		eier		
and 2 sh lealth and m 27 is π		19a. Informant's Name/Relation Philip Donahoe		<u> </u>	6 Gra	ason Cou	rt R	ockville,	MD 20	850	
Pages 1 ment of H ant: If Ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (			ate of	esition (Name of matory or other pl Heaven (	em.	July 31, 2008	Silv	cation - City or To ver Spri	
permit Depart Import any Inj		21. Signature of uneral Service	icense	12	22	2. Name and Add	ress of Facilit	y DeVol Fur ark Dr. G	neral aither	Home sburg, N	1D 20877
Physician /Medical Examiner		shock, or hear failure. Lis Inn hediate Caus. (Final disease dition resulting in death)	t only one cause on Res	t Jused the dea ach line. pirator o (or as a consec oke	y Fail		ying, such as	cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
ficate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course Checoe or night that initiated events resulting in death) Last	S c	o (or as a conse							
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  On the Funeral Director. After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	1 ☐ Liv	outcome of pregree birth 2 D Fetegnant at time of known	al death 3	☐ Ectopic pregnal ☐ Other (specify)			_ 2	23d. Date of deliv Month	ery Day Year
w requires that sheet signed should be det	è	Part II. Other significant condit		death but not re	sulting in the u	nderlying cause g	iven in Part I.				the cause of death? bably 4 🔀 Unknown
The law requested has been page 2 should	Completed	Lung Cancer						24a. W al po 1 □ Ye	utopsy erformed?	24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
nysician nis certiffi director,	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☒ No	Hoepital:	∏Inpatient 2 [	☐ ER/Outpatie	nt 3□DOA	thor:	of Death (Check on		6 □Other (Speci	ffy)
To the Hospital or Attending Physician: The I within 24 Hours effer dea h. To the Funeral Director Affer this certificate h completely filled in by the funeral director, page	Certification: T	3 ☐ Suicide 6 ☐ Could	ing (Mo	te of Injury onth, Day, Year) ce of Injury - At h	28b. Time o Injury	W	∐Yes 2 □	No	be how injury		al Route Number,
lospital or / hours after uneral Dire		29a. Certifier 1 Certify	ing Physician: To t	he best of my kn	eify) nowledge, deat	h occurred at the	time, date ar	City or nd place, and due to ath occurred at the tire	Town, State, the cause(s)	) and manner as	stated.
To the H within 24 To the F complete	Medical	29b. Signature and title of certification	and ma	anner stated.			nse number		29d. Dat	te signed (Month,	Day, Year)
15		30. Name and address of perso			em 23a) (Type,			da, MD 20	-	.y 2.J 9 2(	
Sta	ate	Dr. Andrew Won	7) 32	Registrar's Sign		SC DI.	Periles	ua, FID ZV	O1/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Charles Bailey GOLDSTEIN 5:29 P 2008 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital
Social Security Number 6. Sex Silver Spring If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 M 2 □ F 78 194-22-2092 Illinois June 19, 1930 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2 No Silver Spring Director Montgomery Maryland 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 20902 612 Sisson Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW I] 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No white Specify. WW II 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Salesman i 2 should be filed w h and Mental Hygier is marked other th 18. Mother's Name (First, Middle, Maiden Surname)

Ida Silverman 17. Father's Name (First, Middle, Last) Be Joseph Goldstein permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evone. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Sisson St., Silver Spring, MD 20902 Mary Lynn Goldstein, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State <u>Judean Memorial Gardens 07/28/08</u> 4 □ Donation 5 □ Other (Specify) Olney, MD 21. Signature of Funers Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part 1 Each The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between 2 Year'S immediate Cause (Final disease or condition resulting in death) Ischemic Cardiomyopathy **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-trai Due to (or as a consequence of) Box 68760, physician Physician/Medical the. attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) ed by the a P.O. TYPS 2 No 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chronic Kidney Disease Stage 5 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 XNo 2 No 1 ☐ Yes 1 ☐ Yes spital or Attending Physician: Theory after death, neral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the I within 2 and manner stated.

24

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

29b. Signature and tills of certifier

Mark S. Rosen,

31. Date filed (Month, Day, Year)

3941 Ferrara Drive, Wheaton, MD Registrar's Signature



29c. License number

D 20400

20906

29d. Date signed (Month, Day, Year)

July 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Green Jr  $J_{uly}^{\text{Month}}$ 24,2008 William D. 4:20pm 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan 23, 1920 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) Months Days Hours 1 X M 2 □ F 717-18-6584 88 Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits Washington DC 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20007 United States 2818 P St, N.W. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ★No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 1 Married If Yes, Give Year or Dates 1 ☐Yes 2 🛣 No Specify. SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cottege (1-4or 5+) NASA Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Jenkins William Duncan Green, Sr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2818 P St., N.W. Washington DC 20007

1 ☐ Yes 2 ☐ No

DOU 66269

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Date

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Year

**Physician** /Medical Examiner

**Physician** 

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Macifael Examiner must be rufflied at once.

Baltimore, Maryland 21215-0036

/Medical

10a State

DC

Grace Green/ Wife

20a Method of Disposition

Director

Funeral

Completed

Be

၉

attending physlcian and for use as the burial-transi signed by the certificate has been si rector, page 2 should I funeral director, After this al or Attendir s after death.

Sreen William (4) Division of Vital Records,

Examine Physician/Medical þ Completed Be Certification: To

IF FEMALE 27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Babak Piibul, MD

20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-29-08 National Crematory Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebrovascular Accident disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Union in Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24☐ No 1 □Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1√ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Marient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

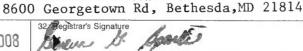
State Registrar

Medical

5 ☐ Pending investigation

6 ☐ Could not be

determined



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



within 24 hours after death To the Funeral Director: filled in by the

۵

npletely

DHMH 17 Rev 1/2001

State

Registrar

Sirak Lemma, M.D.

28

2008

31. Date filed (Month, Day, Year)

souls?

32. egistrar's Signature

1500 Forest Glen Road

Silver Spring, MD 20910

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Helen Gajewski /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salis bur Wicomico ake DICE 8. Date of Birth (Month, Day, Year) Oct. 29,1914 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday Social Security Number **Funeral** Months 1 □ M 2 🛛 F New York 071-24-9717 93 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show at المنازات ال 1 ☐ Yes 2 X No Director Riverhead Suffolk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11901 USA 1015 West Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White \$ 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 is marked other Injury or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked offth any Injury or other traumests. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Sirko Sadie Machata 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 198 Shade Tree Lane, Riverhead, NY 11901 Barbara Irvin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 XRemoval from State 4 ☐ Dongtion 5 ☐ Other (Specify) Sacred Heart Cem. 18/1/2008 Cutchogue, New York 21. Sign ture of Funeral Service 22. Name and Address of Facility eller Funeral Home, P. O. Box 207 06 Main Street, East New Market, MD 21631 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DRMENTIA STACA /Medical Due to (or as a consequence of) Examiner RRN A ACUTR Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to for as a вопасонила» uff Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) attending physician death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy perform<u>ed</u> 217 No certificate 2 7 No 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ ¶o 1 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 27. Manner of Death Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 2 Accident

Box 68760. P.0. Division or Vital Records,

Certification:

5 ☐ Pending investigation

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 20057410 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPICE SHUMMWARLI CEAS

State

Medical

31. Date filed (Month, Day, Year) Registrar

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar 25668 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 10:45 A M George Milford Grebb 20 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Atlantic General Hospital Worcester Berlin 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea, 5/2/1924 5. Social Security Number 7. Age (In yrs. last birthday, Hours Days Months 1**X** M 2 □ F 84 NY 131-18-7150 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Berlin Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 328 William St. USA 21811 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify. Specify: white 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Equipment Operator County Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Grebb Gertrude Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Spurrier / niece P O Box 148, Selbyville, DE 19975 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 7/23/2008 Berlin, MD 22. Name and Address of Facility 21. Signature of Funeral Service Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final scher disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐Yes 2 ☑No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

72/21/20/50 that the death certificate be executed 7150 Box 68760, 10 SOL Becords, law requires Hospital or Attending Physician: The Vital of Division

Physician/Medical Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Completed by After this certific funeral director, Be Medical Certification: To reral Director: To the Hospital o within 24 hours af To the Funeral D completely filled i

4 🗌 Homicide

29b. Signature and title of certifier

29a Certifier (Check only one)

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

2

MD

**Funeral** 

**Director** 

is 1 and 2 should be filed within 72 hours after death with the Marylar of Heatth and Mental Hygiene. It has a 12 is marked other than "natural", or items 23a or 28a-f show 27 is marked other than "natural", or items 7 in the Polithica is other traumatic event, its Medical Economic must be polithed a

permit. Pages 1 Department of H Important: If ite any injury or ot once.

**Physician** 

/Medical

Examiner

7/20/2008 6 1045 1and 21215-0036

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DOD

Maryland

Baltimore,

	David Kee	den MD	006	2670	0-
	30. Name and address of person who comple	eted cause of death (Item 23a) (1	Type, Print)	0 0	
BAIDTI	David Reeder	500 Mark	set Street	Suite	101 1
Stat	31. Date filed (Month, Day, Year)	32. Registrar's Signature			
Registra		Brown &	pole		
		1			

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 17 8:59 P ROBERT LEROY HURLEY 2008 JTR JULY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye Aug. 12, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Year. Days Hours 1 🕅 M 2 🗆 F 213-04-4795 Director 34 1973 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, it a Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 110 South Jefferson Street 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 0. 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within than and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Leroy Hurley, Barbara Jean Hessong ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Christy Miller / Sister 13419 Blue Ridge Ave. Blue Ridge Summit, PA 17214 Date 24, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Frederick, Maryland Resthaven Funeral Services, Skkot Cody P.A 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 21. Signature of Service Lic Mee Approximate Interval Between Onset and Death 23a. Perr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician DAVXIA ninute disease or condition resulting in death) /Medical Due to (or as a consoluence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of): attending physician pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) o 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an certificate has autopsy performe Vital 1 □Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2 No 1 Inpatient 2 XER/Outpatient 3 □ DOA Certification: To After this o funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 impen 1 Natural 5 ☐ Pending investigation Hanged 1 ☐ Yes 2 Accident
3 Suicide
4 Homicide JULY 17. cables Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Jefferson Stock filled in by determined at home within 24 hours a To the Funeral I completely filled Frederick Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

Street Frederick MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MDDME

32. Registra

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	Funeral				e (In yrs. last		If Under 1 Yea			8. Date of B		•	sirthplace (State or Foreign		
	Director		219-20-8091	1□M 2 <b>X</b> 2F	8	4. Yrs.	Months Day	/s Hours	Min.	8. Date of B	ay, Year)	Ma	ryland		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lor	ation					· I	10d. Inside City Limits		
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	er des items	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of Yes, specify C	of Hispanic Or uban, Mexica	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	0-				
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d 2	filed v Hygie other t		12th 17. Father's Name (First, Middle, La	lyr_			CIGIA	18. Mothe	er's Name	(First, Middle			Gediley		
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lary	and N is mai	_	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Stre	et and Numb	er or Rura	l Route Numi	ber, City o	r Town, State	, Zip Code)		
	and and the sealth im 27	n	Georgianna Chr	istmas(Si				ut Av							
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Predict Exaction in the Item of Dece.		20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3		cem	e of Dispos etery, crem ₩⊝1	sition (Name of natory or other p Li i 1 1	olace)	ه 7-26	ate _08	1				
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The same	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cereb	rovar	scula	L ACC	raint	- 13	scheir	vi C		Onset and Death		
-	/Medical Examiner		Toodking in dodain	Due to (or as								Interval Between Onset and Death			
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68760,	The law requires that the death certificate be e tate has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Medical		d											
Вох	eath certific attending p for use as	Ju/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregna	1001				23d. Date of c	delivery		
О. В	at the deal by the att tached for	sicis	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)					Month	Day Year		
Р.	that th		Part II. Other significant conditions	contributing to death bu	ıt not resultin	a in the un	derlying cause	niven in Part I		23e. Did	tobacco u	se contribute	to the cause of death?		
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Division	al or Attending Physician; s after death. il Director: After this certifica ed in by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ry - At home . (Specify)	, farm, stre	et, factory, office	е	2	8f. Location	(Street an	d Number or	Rural Route Number,		
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	To the Hospital or Atta within 24 hours after de To the Funeral Directa completely filled in by th	Medical	29a. Certifier (Check only one) 1 Certifying I	Physician: To the best of miner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the estigation, in m	time, date ar y opinion, dea	nd place, a ath occurre	and due to the ed at the time	e cause(s) , date and	and manner place, and d	as stated. ue to the cause(s)		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Year Henry Joseph Heilmeier 25, July 1:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 15546 Brandywine Road Brandywine Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 74 Director 216-30-3845 01/24/1934 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examinar mind in a content traumatic event. 10c City Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2√ No MD Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.
14. Race - American Indian, 15546 Brandywine Road 20613 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 N954-If Yes, Give Year or Dates: 1956 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Š 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ludwig Heilmeier Fanny Brandner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8196 Pine Boulevard, Lusby, MD 20657 David W. Heilmeier/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 07/29/2008 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 22. Name and Address of Facility Huntt Funeral Home, Inc. M01436 3035 Old Washington Road, Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arterios derotic Hypertensine Heart Dis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 1□ Yes 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 5 ☐ Pending investigation 1-Natural Injury 1 TYes 2 TNo 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State JUL 29 Registrar

		-	For Amend#23 part I, state Registrar Per Phy. 8/5	TI State of Ma /08 CMH AACO H	ryland <sub>1</sub> /7) Ealth dep	epartment e pertificate	82.08 of Deat	<b>728708a</b> n	tal Hygie Reg.	ne No. 200	8	25672			
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Deceden If Yes, specify 1 ☐ Yes 2 ☒			Yes or No- in, etc.)	14. Race - Black, Specify:	American White, etc Whi	c.			
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Baltimore, Maryland 21215-0036	tal History	Be	17. Father's Name (First, Middle, La Charles Pa					other's Name <i>(Fir</i> E <b>dith To</b>		iden Surname)					
<u>₹</u>	d Men narke	유	19a. Informant's Name/Relationship		19h	Mailing Address (S				City or Town St	ate Zin (	Code)			
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	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of	1 ichi C	zace ix	Tur Iuriu							
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2/8	cate to	dical		d					Annapolis, MD 21401 Date 20c. Location - City or Town, State 4/2008 Glen Burnie, MD Ardesty Funeral Hoem, P.A. Annapolis, MD 21401 For respiratory arrest, Approximate Interval Between Onset and Death						
Box 6	es that the death certific igned by the attending p be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 □Live birth 4 □ Pregnant at	2 🗆 Fetal death	3 ☐Ectopic preg				23d. Date of delivery Month Day Year					
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$\#_{\mathcal{I}}$ Division or Vital Records, $^{h}$	The law requires that the ate has been signed by th page 2 should be detache	d by Pl	11000	s contributing to death bu	nt not resulting in	the underlying caus	se given in P	art I.		cco use contrib 2 ☐ No 3		e cause of death? ably 4 nknown			
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> >	hysic this ce	2	1 Yes 2 No	Hospital:		patient 3 DOA		Nursing Home				)			
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ISio	ttend death tor: /	Certification:	2 Accident investiga 3 Suicide 6 Could no	t be 280 Place of inju	ırv - At home, fai	m, street, factory, o			Location (Stre	eet and Number	or Rural	Route Number,			
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	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical C													
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			30. Name and address of person w	ho completed cause of de	eath (Item 23a) (	Type, Print)	· Dra	الم	~ }	nnapoli	3 1	1021401			
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 23 2008 6:35 a Elizabeth Burhans Hanna July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 10 Olney Mill Court Montgomery Olney If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 ₽ F Yrs. Director 97 May 16, 1911 577-03-8091 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expressiver must be realfied at 1 √Yes 2 No Director Maryland Prince George's Hyattsville the ! 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 20782 5605 Queens Chapel Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2√ExNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. ģ 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien important: If Item 27 is marked other tha any Injury or other traumatic event, the Agnee. Own Home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Milton Rielley Louise Burhans ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Olney Mill Court, Olney, MD 20832 Mark D. Hanna/Son 10 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 28 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Fort Lincoln Cemetery Brentwood, Maryland 21. Signavre of Funeral Service Licens 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring. MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final **Physician** Superior Vena Cava Syndrome 4 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Non-Small Cell Carcinoma 6 months Sequentially list conditions Due to for as a consequence of Examiner d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed physician and s the burial-trans Due to (or as a consequence of): 68760 Physician/Medical requires that the death certificate attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown been signed by should be detact ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2x No 3 Probably 4 Unknown 1 ☐ Yes Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed certificate | 1 □Yes 2 kg No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1∐Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA this Certification: To Son's After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Residence 1 X Natural 5 Pending To the Hospital or Augustin 24 hours after death.

To the Funeral Director: Af 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D35996 July 23,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burrell, MD 2730 University Blvd., #400, Wheaton, MD 20902

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

25

2008

32 Registrar's Signature

		1 - For State Registrar	ate of Maryland		artment of rtificate of		and Mental Hy	/gienę2 () Reg. No.	08	25674
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, D	ay, Year)	Count	
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e Mar Ba-f sh rtified	Director	MARYLAND ANNE ARUNDI	EL		ANNAPO			10a. Citizen of		1 ☐ Yes 2 <b>X</b> No
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ns 23	Funeral	11 Marital Status 12. V	Vas Decedent Ever in U.S	S. 13.			igin? (Specify Yes or N n, Puerto Rican, etc.)		ace - America	an Indian,
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II yidil should bad Menta marked imatic e	은	MILTON COFFROTH  19a. Informant's Name/Relationship (Type. F	Print)	19b. Maili	ng Address (Stre	l	Y DARLINGTO ber or Rural Route Num		n, State, Zip	Code)
nd 2 safth an attraction reference r		SHIRLEY M. SMITH/DAU	*				POLIS, MARY	-		
of Heg		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Remo	20b. Pl	ace of Dispo	osition (Name of matory or other o E CREMAT	(ace)	Date	20c. Location	- City or To	wn, State
Dallillor Demit. Pages Department of Important: If if any injury or o		4 ☐ Donation 5 ☐ Other (Specify)	CENT	ER			JULY 22,2008			
permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	м0067	$\frac{1}{2}$ $\frac{2}{R}$	2. Name and Add REMATION OAD, ANN	Facility AND 1 IAPOLIS	ity FELLOWS, FUNERAL CAR S, MARYLAND	121401	, 814	BESTGATE
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218		30. Name and address diverson who comp				ורים שו	ANNADOLTO	MADOT	ANTO 21	401
SAY (),	tate	ADITYA CHOPRA, M.D., 31. Date filed (Month, Day, Year)	32. Legistrar's Signa	turg_	UE, SULT	LE Z31	, ANNAPULIS	, MAKIL	AND CI	401
Regis		JUL 2 4 200	32. Tegistrar's Signa	D. Y	The same					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death tones Day **Physician** 1034 M e nes 22 500g /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Cocation of Death Examiner Suburban mon 509 Va e) Daner 6. Sex If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Hours 1**⊠** M 2□ F Days 578-92-5912 Director 48 Jan.21,1960 Wash, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Director MD Montgomery Germantown 1 XYes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20874 U.S.A. 39 Cherry Bend Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 126 es 2 □ No If Yes, Give Year or Dates: 79-8 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status should be filed within 72 hours after 1 Never Married 2X Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ 79-81 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Driver Bilmin Heating Co 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Colenester B. Jones, Sr Shirley E. Beckwith ၉ 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacy E. Hopkins-Jones 39 Cherry Bend Ct, Germantown, MD 20874 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page Department of Important: If any injury or once. ò 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD/Nat'l Mem. Park 7/29/08 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, Signature of Funeral Service Licensee 246 N. Washington St,Rockville,MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ome disease or condition resulting in death) 15551Ve /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 2 No 2 🗆 X40 1 □ Yes 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2 □ No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗌 Natural 5 Pending investigation 07 20 08 | 1950 M | 1L 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) death. ellon head 1 □Yes 2 No Accident 3 Suicide branch t 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) BaltimoreR or A 4 - Homicide To the Hospital within 24 hours a To the Funeral I street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and tive 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and who completed cause of death (Item 23a) (Type, Print) 20815 5530

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

28

2008

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			1 - For State Registra MEND#20b, C, perF		-	partment of H				
			1. Decedent's Name (First, Middle, Last)	H/-29-08, HM	V,IVDLO U	sitincate of	Death	2. Date of Death	J. No.	3. Time of Death
	Physicia	an		_	ONES			Month	Day Yea	ar
	/Medic		60015		ONES		- Landing of Donath	67	2 2 2 c 4c. County of D	0 6
1	Examin	er	4a. Facility Name (If not institution, give s		-		r Location of Death			
			Washington Adventi		all In yrs. last birthda	Takoma		R Date of Righ	Montgo	mery Birthplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex 1	M 252 F 7. Age (	94 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, )	(ear)	Country)
	Director		Usual Residence of Decedent		94			Jan. 12,1	914 VI	rginia
	and and		10a. State 10b. County		IOc. City, Town or	Location				10d. Inside City Limits
	Aary f sho	0	Md. Montgomery	-	Takom	a Park				1☆ Yes 2 No
	28a-	ect	10e. Street and Number		Takun	10f. Zip Code		100	g. Citizen of What	Country?
	with	Ö				,	2			
	eath	era		2. Was Decedent Ev	erin IIS 1	2091. 3. Was Decedent of H		pecify Yes or No-	U.S.	M • merican Indian,
	Itan	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		/hite, etc.
36	rs af	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give 22 Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify:	Black
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ithis than "natural", or Itams 23a or 28a-f show ant, the Macreal Exam that near the molified a	ed	15. Decedent's Educ	ation	16a. De	cedent's Usual Occup	ation	10	6b. Kind of Busine	ss/Industry
15	in 72 n "na	Completed	(Specify only highest grade	completed)	- life	ve kind of work done  DO NOT use retired	during most of won d)	king		
12	with iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		lousekeepe	r		Janitor	ial
b	filed Hyg otha	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, Ma	aiden Sumame)	
Maryland	d 2 should be filed within 72 hours after death with the Marylan Ih and Marial Hygiene. It had with the statural, or Itams 23a or 28a-f show 1 is marked othar than "natural", or Itams 23a or 28a-f show traumatic avant, Iha Macinal Examera must be notified at	To B	Robert Loucas				Bess	sie A.	Richards	
2	shou nd M mar	<b> </b>	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Ma	illing Address (Street			City or Town, Stat	e, Zip Code)
S	and 2 salth a n 27 Is		Charlotte Johnson	(Niece)	709	Colby Ave	. Takoma	Park, Md	. 20912	
<u>6</u>	- T = 5		20a. Method of Disposition	`	20b. Place of Dis	position (Name of		Date 2	Oc. Location - City	or Town, State
Baltimore,	Pages nent of thant: If its ant: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	Lincoln	Mem Cemete 11 Cemete	tery	26 2008 \$	uitland,	Maryland
₩	permit. Page Department o Important: If any injury or once.	1	21. Signature/of Funeral Service License	an 1						
Ba	permit. Departr Imports any inju		1/2	1		22. Name and Addre Chambers F 801 Cleve	uneral Ho	ome & Crei	matorium 10 Md 2	,P.A. 0737
			23a. Part1. Enter the disease, or complic	ations that caused the						Approximate
l,			shock, or heart failure. List only on	e cause on each line		·	_		,	Interval Between Onset and Death
	Priysician	li	Immediate Cause (Final disease or condition resulting in death)	1200	MONI	DRY 1	EDEN	n A		
	/Medical Examiner			Due to (or as a	consequence of):					
		<u></u>	Sequentially list conditions, b.	Due to (or as a	consequence of):	ME O	MONI	7		
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Consequence on).	COCLAL	51	C 10 C1 (		
	and and I-trar	хап	that initiated events c. resulting in death) Last		Consequence of):	COCCAL		= 17(-		
8760,	ficate be executed physician and s the burial-transit	三田		000 10 (0. 00 0	30/103 q 30/103 31/1					
87	cate ohysi the t	dicail	d							
9 ×	that the death certifi ed by the attending I detached for use as	0.0	IF FEMALE:	lo If yes outcome of	prognancy					4-6
Вох	ath c	Physician/M	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of 1 Live birth 2	Fetal death	3 Ectopic pregnancy	+		23d. Date of Month	Day Year
o.	ie de the a hed f	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	me of death	5 Other (specify)				
P.O.	d by	Phy	Part II. Other significant conditions con	rainceina en deneb bore	mat annutain — in th		on in Dard I	22a Did tob	acco usa contribut	e to the cause of death?
ŝ	res the	by	PLC 57 R-1 D	•	DIFF	, ,				Probably 4 Munknown
orc	w require been si should l	ted				1 6 6	21112	1 100	. 20140 30	11 lobably 4 (Bolikilotti)
of Vital Records,	law ras be	Completed by	$\sim$	ATORY				24a. Was an autopsy	prior	autopsy findings available to completion of cause of
<u> </u>	sician: The law s certificate has b irector, page 2 s	or	EXPLOR.	A TORY	LAR	ARUOFO	MY	perform	ed? deat	h? Yes 2□No
ita	ian: rtifica	Be (	25. Was case referred to medical		_		26. Place of Dea	ith (Check only one		
f V	nysic IIS Ce direc	2	1 Yes 2 PNo	ospital: Inpatien	2 ER/Outpa	tent 3 DOA	ner: 4 ☐ Nursing H	ome 5 Resider	nce 6 Other (	Specify)
0	ding Phys n. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day	28b, Time	of 28c. Injur	v at	28d. Describe how		
0	ath. ath. rr: Af ne fur	atic	1 Accident 5 Pending investigation	(	, , , , , , , , , , , , , , , , , , , ,		Yes 2 □ No			
Division	Atta acto by th	ific	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm,	street, factory, office		28f. Location (Stre City or Town,	eet and Number o	r Rural Route Number,
Ö	al or	Certification:		building, oto.	(Opoony)			oy o o,	Jiaio,	
	To the Hospital or Attanding Physician: The law requires that the death certification 24 hours alter death.  To the Funaral Diractor Affer this certificate has been signed by the attending to the Funaral Diractor. Affer this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Sal	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	icien: To the best of	my knowledge, de	eath occurred at the ti	me, date and place	, and due to the car	use(s) and manne	r as stated.
	n 24 n 24 na Fu	Medical	(Check only 2 Medical Examinone)	er: On the basis of e	ed.	investigation, in my c	opinion, death occu	rred at the time, da	te and place, and	due to the cause(s)
	To ti withi To ti	Ž	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (M	fonth, Day, Year)
/	3		Warlata	_		010	1971		G71 231	2008
ر -	>		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Ty				of D. I.	000 000
			30. Name and address of person who con	M.D	7610	CABROC	- HAZ	. #230	W. 160	) 2 0 9445
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar		1 4				77
	Registr		ии 2.5 200	8 France	. It le	COALL!				

08-05854	
Ronnie Jones	

onnie Jones	1- For State Registrar	f Maryland / Departmen <i>Certificate</i>	it of Health and Mental Hy e of Death	ygiene Reg. No.	2008 2567
Physician/	Decedent's Name (First, Middle,Last)			Date of Death     Month Day	3. Time of Death
Medical Examine	Ronnie Elwood  4a. Facility Name (if not institution, give	Ollin Jones	4b. City, Town, or Location of Death	July 31, 2008	County of Death
	Penninsula Regional Medic		Salisbury		/icomico
Funeral	Social Security Number     6. Sex	7. Age (In yrs. last birthda	ay) If Under 1 Year If Under 24Hrs Months Days Hours Min	· '	DD/YYYY) 9. Birthplace (State or Foreign
Director	219-78-60151X	4 2 F 4 9	Yrs. World's Days Hours Will	09-02-1	958 Country) MD
any	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or I	Location		10d. Inside City Limits
Maryland 28a-f show at once,	MD Wicomi	co Salisbu	ıry		1 Yes 2 No
he Maryland  on 28a-f sh  lifted at once	10e. Street and Number		10f. Zip Code	10g. Citiz	en of What Country?
			21801 3. Was Decedent of Hispanic Origin? (Sp	USA pecify Yes or No-	14. Race - American Indian, Black,
	1 X Never Married 2 Married	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		White, etc.
5-0036 led within 72 hours after death yigene, other than "natural", or ite the Medical Examiner must Commissed by Firm	3 Widowed 4 Divorced	f Yes, Give Year or Dates:	1 Yes 2 X No specify: Bl		Specify: Black
2 hours	15. Decedent's Education (Specify only Elementary/Secondary (0-12)		cedent's Usual Occupation (Give kind of ving most of working life. DD NOT use ret		ind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "naturate Medical Example Compulered	11		struction Worke	r De	ninsula Roof
215-0036 be filed within 72 ntal Hygiene. Red other than " ent, the Medical I			18.Mother's Name	e (First, Middle, Maiden	Surname)
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than it event, the Medical To Be Comple		pe. Print ) 19b. N	Mary E Mailing Address (Street and Number or	:lizabeth Rural Route Number. Cir	
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If iten 27 is marked o injury or other transmatic event, the	Ida Gillespie	/ Friend   28	3445 Adkins Rd.	Salisbury	MD 21801
Baltimore, oemit. Pages I am Department of Heal Important: If iten Injury or other tra	20a. Method of Disposition  1 Purial 2 Cremation 3		Disposition (Name of cemetery, or other place)		ocation - City or Town, State
timent or or or or	4 Donation 5 Other Specify:		22. Name and Address of Facility Be	7/2008	ort Neck MD (Vienna)
Bal permi Depar Impor	21. Signature Funeral Service Licens		426 E. Dover St	nnie Smit	th Funeral Home
Physician	23a. Part I. Enter the disease, or compile failure. List only one cause on each		enter the mode of dying, such as cardiac		
/Medical	Immediate Cause (Final disease a.	Hypertensive car	diovascular diseas	e .	Death
	h	ue to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate D	ue to (or as a consequence of):			
led nsit	(Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):			
		AMENDED 23a,PII,27,	perME, g882 8/12/0	8 TT	
J. Box 68760, the death certificate be executly the attending physician and sched for use as the burial - tra	X UNPENDED	23c. If yes, outcome of pregnancy	, 8000 0,12,0		d. Date of delivery
tox 6876 eath certificate eath certificate eath certificate for use as the land	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3 Ectopic pregn		Month Day Year
Box 687 death certifics the attending ped for use as the	1 Yes 2 No 9 Unknown	4 Pregnant at time of death 5 Unknown	Other (Specify)		
that the date by the detached		contributing to death but not resulting in	n the underlying cause given in Part I.		use contribute to the cause of death?
Records, P.( The law requires that freate has been signed , page 2 should be determed by	Cocaine use				No 3 Probably 4 ✓ Unknown
cords, law requir				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal Rection: The certificate ector, page			Of Disease ( Desaits (Observed)	1 <b>Y</b> Yes 2 N	
Vital Recysician: The list certificate director, page		ospital: 1 Inpatient 2 ✓ ER/Outp	26.Place of Death (Check patient 3 DOA Other Nursi		ence 6 Other:
n of \ding Phy.  After the funeral	27 Manner of Death	28a. Date of Injury (Month, Day, Year) 28b. Tin	ne of Injury 28c. Injury at Work?	28d. Describe how inju	ury occurred
Sion vitendi death. ctor: yy the f	Natural 5 Pending 2 Accident Investigation	n	1 Yes 2 No		
Division of Vital Records, P.O. spltal or Attending Physician: The law requires that th rours after death.  neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At home, farm (Specify)	n, street, factory, office building, etc.	28f. Location (Street a or Town, State)	and Number or Rural Route Number, City
Hosph 24 hour Funer tely fill			occurred at the time, date and place, an	d due to the cause(s) ar	nd manner as stated.
Divis  To the Hospital or within 24 hours after To the Fineral Dire completely filled in b	one) 2 Medical Examiner:	On the basis of examination and/or inve and manner stated.	estigation, in my opinion, death occurred		
2	29b. Signature and title of certifier		29c. License number O.C.M.E.		Date signed (Month, Day, Year) y 31, 2008
3	30. Name and address of person who c	Omnieted cause of death (Item 23a)	O.G.IVI.E.	301)	7 0 1, 2000
			enn Street, Baltimore, MD 2120	)1	
Stat	VIII. VIE .WII	32 Registrar's Signature	Karll o		
Registra		- Annon to V	A 200 AU		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARIAN Month Day /Medical JANET KWASNESKI JULY 26, 11:55A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL 4c. County of Death FREDERICK FREDERICK 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1 □ M 2 □ 194-16-1228 Birthplace (State or Foreign
Country) **Director** Months Days 84 Dec 8, Usual Residence of Decedent Pennsylvania 10a. State 10b. County the Medical Examiner most be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland Director Frederick Frederick 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1820 Latham Drive items 23a 21701 filed within 72 hours after death Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 0 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ Yes Give 3 XWidowed 4 ☐ Divorced 1 ☐ Yes 2 X No Year or Dates: white Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lighty or other traumatic event 900g. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Josephus Majchrzak Ladislav Manikowska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Rice - daughter 2250 Bear Ben Road, Frederick, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Resthaven Memorial 7-30-2008 Frederick, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Marow aline 1621 Opossumtown Pike, Frederick, Maryland 21702 Canelle 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Spiritra Onset and Death /Medical Due to (o. as a consequence of): Examiner aPO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 ☐ Fetal death 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 23e. Did tobacco use contribute to the cause of death? JChizophenia Completed 1 Kes 2 No 3 Probably 4 Unknown MA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? HTW autopsy Hospital or Attending Physician; 1 ☐ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Be 26. Place of Death (Check only one Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 mpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 1 Accident 28c. Injury at Work? 5 Pending 28d. Describe how injury occurred after death. investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

2 Core

Martha Pierce

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 2 8 2008

046248

300 W. 9th Street, Frederick, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** рм D. 2008 12:53 Khawaja July 23, Fayez /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ★M 2 ☐ F Months Days Hours Min. Director 577-02-0388 Jan. 12, 1932 Jordan Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 23 or 28a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show orther thaumatic event, Ite Mactical Examinator and be notified at Director Maryland Montgomery 1 ☐Yes 2 ☐No Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11118 Norlee Drive 20902 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married 1 ☐Yes 2 ☐No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 6 Business Owner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daifallah I. Khawaja Shafiqa Khoury 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raed Khawaja/Son 20085 Northville Hills Terrace, Ashburn, VA 20147 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any Injury or oth 25, xx Burial 2 ☐ Cremation 3 ☐ Removal from State July 2 2008 Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) Silver Spring, Maryland 21. Signature of Funeral/Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Septic Shock /Medical Due to (or as a consequence of) Examiner Cystitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) be executed burial-transi Pneumonia resulting in death) Last Due to (or as a consequence of). attending physician for use as the burlal Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 1 ☐ Yes 2 ☐ No 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 X X No ۴ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D65305 July 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabila Khan, MD 1500 Forest Glen Road, Silver Spring. MD 20910

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

5

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Records.

of Vital

Division

Registrar's Signature

auren E. Kelly		State of Maryland / Department of Health and Mental  Certificate of Death		Reg. No	200	8 2568		
Physician	7	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Do Month	eath Day		3. Time of Death 2250 hrs		
ledical Examine		Lauren Elizabeth Kelly  4a. Facility Name (if not institution, give street and number)  9003 Contee Road # C  4b. City, Town, or Location of D  Laurel	July 27,	4	4c. County of Death Prince George			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	4Hrs. 8. Date of Min. 04/1	Birth(M	M/DD/YYYY) 9. Bir			
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	1017			10d. Inside City Limits		
^ ≥	Director	MD Prince Georges Laure1  10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Cou	1 X Yes 2 No		
ith the Mar 23a or 28 notified a		9003 Contee Road #C  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	? ( Specify Yes or	No-	USA	rican Indian, Black,		
er death w	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:			White, etc.			
2 hour	eted by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)		16b	Specify: <b>B1a</b> b. Kind of Business			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	$\circ$		Name (First, Middl	e, Maid		te		
2121 tould be a d Mental s marke tic event	10 Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number		Number,	City or Town, Stat	e, Zip Code)		
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other trauman	+	John P. Kelly, Jr./Father 3905 Hudee Drive  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Mitchell Date		c. Location - City o	r Town, State		
Iltimor nit. Pages artment of nortant: Il	-	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify Ft. Lincoln Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility F	08/11/08	3 B	rentwood	, MD		
Balt Permit. Depart Import	4	23a. Part V Enter the disease or complications that caused the death. Do not enter the mode of dying, such as card	Road I	Bren	twood, M	20722 Approximate Interv		
/Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				Between Onset and Death		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in (earth). Last of the conditions	hypertr	oph	У			
executed an and al - transit	cal Ex	events resulting in death) Last  d.  X UNPENDED  AMENDED PI line a-b, PII 27 per ME	g882 8/2	21/0	8 TT			
Box 68760, a death certificate be the attending physici and for use as the burn hysician/Med		IF FEMALE: 23c. If yes, outcome of pregnancy	pregnancy		23d. Date of delive Month	Pry Year		
	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Hepatic steatosis	I. 23e. D			to the cause of death?		
	Completed		a	Vas an utopsy erforme es 2	prior to			
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hour after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach.		25. Was case referred to medical examiner?  Hospital:   Inpatient 2   ER/Outpatient 3   DOA   Other	Check only one)  Nursing Home 5	Res	sidence 6 🗸 Oth	ner: Scene		
		1 Ves 2 No Englishment 2 Envolupation 2 Sec. Injury at Work?  1 X Natural 5 Pending 2 Accident Investigation	l l	ibe how	injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc.  3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)						
		To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
F 3 F 8	Me	29b. Signature and title of certifier  29c. License number  O.C.M.E.		- 1	9d. Date signed (A	Month, Day, Year)		
2		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201					
Sta Regist								
OCME 2006	01	OOME ORIGINAL						

			1 - StateAmend#10F	State of	of Marylar	nd / Depa	artment of H	Health and N			0.0	05601
		-	1. Decedent's Name (First, Middle			D-CEel	tificate of	Death	2. Date of Dea	Reg. No. 2	UB	3. Time of Death
	Physici /Medic		Marian Priscil	. ,	cev				July 2	23, Day 2008	8 Year	9:00 A M
Barrie .	Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)			r Location of Death		4c. County	of Death	
			7070 Cradlerock				Columbia			Howard		
Н	Funeral Director		5. Social Security Number 258-36-3573	6. Sex 1 ☐ M 2 🛱 F	7. Age (In yrs.	last birthday)  8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 8,	7 Year) 1930	9. Birthp Cour Geor	
	D		Usual Residence of Decedent						1000,	1750		
	arylar show	'n	10a. State 10b. County			ty, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	rect	MD Howard		Col	umbia	10f. Zip Code			10g. Citizen of	What Cour	
	h with	a Di	7070 Cradlerock	: Way #125	;		21044	21045		JSA		,
	r deat	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americ	
36	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Evantiner rust be notified at	by F	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	ried 1 ∐Yes If Yes, G Year or D			l∐Yes 2 <b>∏</b> No	Specify:			y: Whi	
21215-0036	2 hou natura ical E	ted	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	pation	·	16b. Kind of B		
21	within 7 iene. <b>than "r</b>	Completed	(Specify only higher Elementary/Secondary (0-12)		1-4or 5+)	ilife. L	OO NOT use retired	*	ing			
d 2	Hyg Hyg Int,		17. Father's Name (First, Middle,	Last)		Telep	hone Oper	rator 18. Mother's Nam	e (First Middle			ernment
Maryland	~ = 0 2	To Be	Ralph Martin Ir	_				Lottie B				
lary	2 shou and N is ma auma		19a. Informant's Name/Relations					and Number or Rur				
e, <b>™</b>	1 and Health Sm 27 ther tr		Priscilla Roger	s/daugnte				y Place M	ontgomen Date	20c. Location		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic es once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				sition (Name of natory or other place	ory 07/2		Beltsvi	•	
altir	partme portar y Injur		21. Signature of Funeral Service		/							
<u> </u>	80 E E 8	21. Signature of Funeral Service Licensee Coing Home Cremation  August Hauth M01251 Beverly L. Heckrotte								Clarks	. Box ville	MD 21029
		8 17	23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Cancer							3 years
1	Examiner			Due to	(or as a conseq	quence of):						
	pe tis	iner	Sequentially list conditions, if any, leading to immediate	Due to	(or as a conseq	juence of):						
	xecute and II-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq	uence of):						
8760,	icate be executed physician and the burial-transit	dical		d.	(	,						
	ng phy	Medi	IF FEMALE:									
Вох	death certif e attending id for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregnation	aldeath 3	Ectopic pregnanc	у			ite of delive	ery Day Year
o.	the de	Physician/Me	1 □Yes 2MNo 9 □ Unknown	9 Unk	nant at time of a	death 5L	Other (specify) _					
S, P.	law requires that the death certifi as been signed by the attending 2 should be detached for use as	by PI	Part II. Other significant condition	•	leath but not res	ulting in the ur	nderlying cause give	en in Part I.				ne cause of death?
ord	w requires been signatures should be	ted	Anemia, Emphyse	alid			·		fer	es 2 No	3 ☐ Prob	pably 4 🗌 Unknown
Division of Vital Records,	0 - 0	Completed					<del></del>	<u> </u>	24a. Was a autop	sy	Were auto prior to co death?	psy findings available mpletion of cause of
ta	ilcian: The l certificate ha ector, page		25. Was case referred to medical					26. Place of Deat	1 □ Yes	2 No	1 ☐ Yes	2 □No
Ž	Physician: r this certific ral director,	Fo Be	examiner? 1 ☐ Yes 2 ☐ Xo	Hospital: 1 □	Inpatient 2	ER/Outpatien	t 3 □ DOA Oth				ner (Specif	·y)
o uc	nding Physician: th. : After this certifica ) funeral director, p	ion:	27. Manner of Death 1		of Injury oth, Day, Year)	28b. Time of Injury	Worl	k?	28d. Describe h	ow injury occur	red	
isio	Attending or death. ector: After by the funer	ficat	2 Accident investig	not be	e of Injury - At h	ome. farm. stre	M 1 Deet, factory, office	Yes 2 □No	28f. Location (S	treet and Numl	beror Rum	I Route Number,
<u>S</u>	s after al Dire	Certification: To	4 ☐ Homicide determ	build	ling, etc. <i>(Speci</i>	fy)	,,,		City or Tow	n, State)		
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medical	g Physician: To the Examiner: On the I	pasis of examina	owledge, death	occurred at the til	me, date and place, opinion, death occur	and due to the red at the time, of	cause(s) and m	anner as s	stated. the cause(s)
	o the vithin 2 o the omple	Medical	one)  29b. Signature and title of certifier		ner stated.		29c. Licens	e number	- 1	29d. Date signe	ed (Month,	Day, Year)
	->-0		Dan X.	Mila	Al w	D	0	3057		7-21		
	10/88	}	30. Name and address of person Jon K. Minford,	who completed cau	se of death (Iter	n 23a) (Type, I	Print)			210//		
	Sta	te.	31. Date filed (Month, Day, Year)					wy. COIUM	ora, MD	4TU44		
	Registr		JUL 2 8	3 2008	egistrar's Signa	1. A	neck!					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State of Maryla Stor State Registrar	and / Department of Certificate of		lygiene <sub>Reg.</sub>	No. 200	0 2500
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Randall Scott Keepers	5		2. Date of Death Month D July 31, 200		39 ime of Beath 0 0 1958 hrs
41	4a. Facility Name (if not institution, give street and not 515 South Market Street	umber) 4	p. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 399-64-7963 6. Sex	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Mir		. Cou	nplace (State or Foreign untry) SCONSIN
w any	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick	10c. City, Town or Location	ck			10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 5606 Calvert Drive		10f. Zip Code 21703		. Citizen of What Coun Inited Stat	
or items	11. Marital Status 1 Never Married 2 X Married 1 X Yes 3 Widowed 4 Divorced or Pates:	orces? If Ye	Decedent of Hispanic Origin? (Ss. specify Cuban, Mexican, Puerto Yes 2 X No specify:		14. Race - Americ White, etc.	can Indian, Black, nite
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after begratment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. To Be Completed by I	4	1-4 or 5+) during mo	s Usual Occupation (Give kind of st of working life. DO NOT use re urement	tired)	6b. Kind of Business/li	5 1 11
21215-0036 Uld be filed within 7 Mental Hygiers marked other than e event, the Medica	17. Father's Name (First, Middle, Last) George A. Keepers			Geffers	iden Surname)	
MD 21 id 2 should ilth and Mei m 27 is mai aumatic ev	19a. Informant's Name/Relationship (Type, Print) Marcia Kemp/wife		Address (Street and Number or Calvert Drive,			
Baltimore, A cernit Pages I and Department of Illealt I mportant if item injury or other trau	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal f  4 Donation 5 Other Specify:	rom State Crematory or oth Smithsbur	g Crematory   8/	2/2008	20c. Location - City or Smithsburg	g, MD
Balt permit. Departu Import injury	21. Signature of Funeral Service Licensee		ame and Address of Facility Ke 6 East Church S			
Physician /Medical Examiner	100 Mg 1 Mg 1 Mg 1 Mg 1 Mg 1 Mg 1 Mg 1 M	caused the death. Do not enter the sunshot Wound a consequence of):	e mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	a consequence of):				
n and I - tra	d	28e-f,perME, g8	382 8/8/08 TT			
6876 certificat nding ph ise as the	23b. Was decedent pregnant in the past 12 months?	nant at time of death 5 Oth	al death 3 Ectopic pregr	nancy	23d. Date of delivery Month	/ / Day Year
, P.O. E ries that the signed by the be detached by the bedeached by bedeach	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.		acco use contribute to	
ision of Vital Records, P.O. Box Attending Physician: The law requires that the death r death. retent and the transport of th				24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
of Vital ig Physician: ther this certineral director it To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatient	26.Place of Death (Check 3 DOA Other; Nurs	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	esidence 6 🗸 Other	r: Scene
on of 'ending Pheath. or: After the funeral	27. Manner of Death  1 Natural 5 Pending  Pending	e of Injury h, Day,Year) : FOUND: 2008 1950 hrs	njury 28c. Injury at Work?  1 Yes 2 ✓ No	28d. Describe ho Subject shot	w injury occurred self	
Division o pipels of Attending to the Attending to the Attending to the Attender of the filled in by the fune Certification:		ce of Injury - At home, farm, stree		28f. Location (Str or Town, Sta 5606 Galvert Dr	reet and Number or Rute) 515 S. M.	ral Route Number, City arket St. Frederick, N
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: / completely filled in by the fi	29a Certifier	est of my knowledge, death occur of examination and/or investigat	red at the time, date and place, ar	nd due to the cause(	s) and manner as state	ed.
F × F 2	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mo August 1, 2008	nth, Day, Year)
	30. Name and address of person who completed cau Ana Rubio MD. Assistant Medical		treet, Baltimore, MD 2120	01		9
State Registrar	31. Date filed (Month, Day, Year) 32 F	Registrar's Signature	K)			

Records, P.O. Box 68760 has Division or Vital To the Hospital or Attending Physician:

within 24 hours after death To the Funeral Director:

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Certification:

Medical

29b. Signature and tiple of

31. Date filed (Month

24a. Was an autopsy performe /es 2 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Carroll

2008

310 S. Seton Ave. Emmitsburg, MD Year) 8

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar		State of Ma	aryland	•	artment of F rtificate of I			lental Hy	gienę. Reg. No.	200	8	25684
	Physicia		1. Decedent's Name Tsung Har		st)				-		2. Date of Dea Month July 19	Day		Year	3. Time of Death 2:00 A <sup>M</sup>
1	/Medio				re street and number)			4b. City, Town, or	r Locatio	on of Death	July 1.		County of	f Death	2.00 A
	-Adiiiii		Shady Gr	ove Adver	tist Hospi	ita1		Rockvi	11e			M	ontg	omer	У
	Funeral Director		5. Social Security N 352-88-9	398	E u o D e l	e (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Und Hour	ler 24 Hrs. s Min.	8. Date of Birt (Month, Da Jan. 5,	y, Year) 192	8	9. Birthp Coun <b>Chi</b> n	lace (State or Foreign try) 1a
	death with the Maryland ims 23a or 28a-f show r roust be redified at		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Lo	cation						10	0d. Inside City Limits
	sa-f s	당	MD	Montgome	ery	Ro	ckvill	.e							1⊠Yes 2□No
	or 28	Dire	10e. Street and Nur					10f. Zip Code				10g. Citiz	en of Wh	nat Coun	try?~
	ath w	ral	95 Dawson	n Avenue	T			20850				U.S			
12-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, It s Modical Examinar must be profitted at	by Funeral Director	11. Marital Status 1 □ Never Marri 3 □ Widowed	ied 2 🔀 Married 4 □ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 🖾 No	lispanic an, Mexic Speci		ecify Yes or No Rican, etc.)			White, e	en Indian, etc. nese
<u>ဂ</u>	72 ho	ted	(Snec	15. Decedent's Ed	ducation		16a. Deced	dent's Usual Occup	ation	aget of worki	na	16b. Kin	nd of Busi	iness/Ind	dustry
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DIVIS	<b>5</b> € 5 =	Certification: T	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulding, etc	ry - At hor :. (Specify	ne, farm, stre	eet, factory, office	_	2	28f. Location (5 City or Tov		d Number	or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (	29a. Certifier (Check only one)	1 ☑ Certifying Pt 2 ☐ Medical Exer	nysician: To the best on niner: On the basis of and manner sta	examinati	/ledge, deatl on and/or in	n occurred at the til vestigation, in my o	ne, date	and place, death occurr	and due to the ed at the time,	cause(s) date and	and man place, an	ner as s	tated. the cause(s)
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KEPINCE MENT.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 EVELYN FRANCES LANDON July 26, 4:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 1 ☐ M 2 ☑ F Director 96 Nov. 13, 1911 Maryland 212-10-4434 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Maryland Crisfield Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Hudson Street 21817 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ Specify: 3₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "n. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Francis Howard Vida Jane Tyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau Mary Jean Ward (Daughter) <u> Hudson Street - Crisfield, MD 21817</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Date 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park July 29, 2008 | Crisfield, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mary Beth Bradshaw 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SCVI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of Indiay that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760. physician s the burial Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has 1∏ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No or Attendated after death. death. 3 ☐ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

P.O. Division or Vital Records. To the Hospital within 24 hours a To the Funeral L Hospital

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. – 2U 32. Rhistrar's Sign Vijay Karumbunathan. 2008 State Registrar

29b. Signature and title of certifier

and manner stated.

D 48098

7/28/2008

29d. Date signed (Month, Day, Year)

201 Hall Highway - Crisfield, MD 21817

DHMH 17 Rev 1/2001

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0100 AM Minam 2008 /Medical Juh4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. Sept. 5, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Director New Jersey 1921 151-28-5575 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ita Monital Examine must be notified at any Injury or other traumatic event, Ita Monital Examine must be notified at any pine. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery N. Potomac 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 20878 10840 Tuckahoe Way Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: white ģ 1 ☐Yes 2 No Specify: Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abner Chanin Rose Ruth Rabinowitz ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Grays Lane, Apt. #100, Haverford, PA 19041 Judy Gruber, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Lebanon Cemetery | 07/28/08 4 ☐ Donation 5 ☐ Other (Specify) Islen, NJ 21. Signature of Frontal Service Licensee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se **Physician** MSis /Medical Due to (or as a consequence of): Examiner Grication Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Ye ar Day 5 Other (specify) iis certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Be Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only o e) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Atterious,

within 24 hours after death,

To the Funeral Director: After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 67238. 10

State Registrar

31. Date filed (Month, Day, Year) 28

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39. Registrar's Signature

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30. Name and address of person who completed cause of death (item 23a) (Type, Print) Chini

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Packerlle, MID

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	/Medic		CHRIST  4a. Facility Name (If not institution		ROSEM			YD r Location of Death	Aug.		008 nty of Death	unknown"
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	and w		Usual Residence of Decedent  10a. State 10b. County	/	10c. City, To	own or Loca	ation					10d. Inside City Limits
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5	rs fre	Certification:		Building, et	o. (opcony)				City or Town	i, otate)		
	To the Hospital or Attending Physician: The law requires that the death certilicate be, within 24 hours. Her death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn	edical	29a. Certifier 1 Certifyl (Check only 2 Medica	ing Physician: To the best I Examiner: On the basis o and manner sta	f examination	dge, death and/or inv	occurred at the tile estigation, in my o	me, date and place opinion, death occu	e, and due to the d irred at the time, o	ause(s) and late and plac	manner as ce, and due	stated. to the cause(s)
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	12		30. Name and address of person	who completed cause of d	eath (Item 23	a) (Type, P	Print)	01 11-	1	4		71015
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day July 26, Louise Woodrow Metz 2008 6:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Lorien of Mount Airy Mount Airy Carrol1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. Days Hours 1 □ M 2 X F Director 220-28-8996 4, 1912 Maryland Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ir than "natural", or Items 23a or the Medical Examiner must be 20872 8510 Gue Road Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify. ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Institute Elementary/Secondary (0-12) College (1-4or 5+) 11 Medical Research Technician of Health other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( h and Mental I 7 is marked of Jesse Calvin Walker Lula Maw Beall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health : Peggy Burgee, daughter 8510 Gue Road, Damascus, Maryland other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Mount Olivet Cemetery July 29, 2008 Frederick, Maryland 21. Signature of uneral Service License 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Ef te the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or pach line. Immediate Care (Final disease or condition resulting in death) **Physician** MEUMON /Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed use as the burial-trar Box 68760, physician attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
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9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 2 No page 2 : autopsy perform this certificate funeral director. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 COther (Specify) 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural (Month, Day Year) 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō within 24 hours a To the Funeral I

P.O. I Division or Vital Records, Hospital

10

State

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

and manner stated.

32. Regist

se of death (Item 23a) (Type, Print)

80,

s Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certificate of Death

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAZ

gistrar's Signature

WARY

6 Hustin

31. Date filed (Month, Day, Year)

State

Registrar

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

**ORIGINAL** 

HOSPICR

DHMH 17 Rev 1/200

2008 4c. County of Death

Year 2:33 P

3. Time of Death

comico

 Birthplace (State or Foreign Country) Pennsylvania

Reg. No. 20

2 Date of Death

10d. Inside City Limits 1 ☐ Yes 2 🔀 No

10g. Citizen of What Country?

USA 14. Race - American Indian.

Black, White, etc. Specify: white

16b. Kind of Business/Industry contracting company

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24 Harborview Dr., Ocean Pines, MD 21811

Danville, PA

22, Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Approximate Interval Between Onset and Death

23e. Did tobacco use contribute to the cause of death?

Month

Day

Year

1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ro

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DO058410

SAUSBURYUD UEOZ

P.ODOX 1737

			1 - For State Registrar	State of M	laryland		artment of I		ind Mer		ene ()	08	25690
-	Physici	an	Decedent's Name (First, Middle, L.	ast)					2.	Date of Death Month	n Day	Year	3. Time of Death
	/Media				MARCH	JR.				ULY :	24 2	800	12:05P M
	Examir	ner	4a. Facility Name (If not institution, gi			OMD.	4b. City, Town, o		f Death			ty of Death	
			BERLIN NURSING &  5. Social Security Number 6.		ge (In yrs. las		BERI If Under 1 Year		24 Hrs.   Q	Date of Birth	W	ORCES	TER place (State or Foreign
	Funeral Director			1 <b>X</b> M 2□F	80	Yrs.	Months Days		Min.	(Month, Day,	Year) 1928	Cou	ntry) SYLVANIA
			Usual Residence of Decedent						h.TE	11 229	1920	LEMM	SILVANIA
	rylan		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show frount be notified at	cto	MARYLAND WORC	ESTER	E	ERLIN	I						1 X Yes 2 No
	or 24	Dire	10e. Street and Number				10f. Zip Code			10	g. Citizen o	f What Cou	intry?
	s 238	E I	9715 HEALTHWAY D				2181					SA	
	Item Item	Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces' 1 X Yes 2 □	?	13. 1	Was Decedent of I f Yes, specify Cub	an, Mexican,	Puerto Ric	y Yes or No- an, etc.)		ace - Amen ack, White	can Indian, , etc.
336	urs af	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:	KOREA	1	1□Yes 2ሺ No	Specify:			Spec	ify: W	HITE
-0	2 hou		15. Decedent's E	Education		16a. Deced	dent's Usual Occup	pation		1	6b. Kind of		
215	thin 7 9.	pie	(Specify only highest gi	rade completed)  College (1-4or	5+)	life. l	kind of work done DO NOT use retire	during most ad)	of working				
21	ed wi	Completed	12			MUSH	ROOM GRO	WER			MUSHRO	OOM D	ELIVERY
Jan 1	be fill d oth	Be	17. Father's Name (First, Middle, Las					18. Mother	r's Name (F.	irst, Middle, M	laiden Suma	ame)	
Zi Z	ould Men Marke Marke	10	NEIL B.	MARCH					RTHA	В.		ENDER	
NEIL Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examinet must be notified at ODGe.		19a. Informant's Name/Relationship				g Address (Street						_
H,	1 and Healt em 2 ther		APRIL DAVIS/DA	MUGHTER			RIDGE RO sition (Name of	AD, CH	ILNCOT Date	-	VA Oc. Location	23336	
MARCH Baltimore,	nt of nt of :: If it		1 X Burial 2 ☐ Cremation 3 [		сеп	netery, cren	natory`or other pla	. 1				-	
M.A.	it. Partme		'4 ☐ Donation 5 ☐ Other (Spec 21. Sign y re F neral Service Lice	. ,	UAK		CEMETERY		7/30/0	18	MILLE	RSBUR	G, PA
Ba	permi Depar Impo any ir		11/2/2/11	24			ASTINGS	,		E. SEL	RYVTT.T	F DI	19975
			23a. Part I. Enter the disease, or con shock, or heart failure. List only	nplications that dusc	the death.							11, 11	Approximate Interval Between
	Physician		Immediate Cause (Final	1 - 11			-				les,	1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		s a conseque		ic CARL	01011150	WHI	1	)15E/	52	-
	Examiner		Constant list and distance	b									
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a abhacqua	ndo utj:							
	nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.									
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	s a conseque	nce of):							
876	cate b	dicai		_ d.								-	
9 ×	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregnanc	v					0015		
Вох	that the death cered by the attendin	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant a	2 Fetal de	eath 3	Ectopic pregnanc Other (specify)	:y				ate of deliv Ionth	Day Year
P.O.	at the d by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	it time of dea	ai 5 L	TOTHER (Specify)						
	aires that signed b		Part II. Other significant conditions	contributing to death I	but not resulti	ng in the ur	nderlying cause gr	ven in Part I.		23e. Did toba	acco use co	ntribute to t	the cause of death?
rds	quires n sign	ed by	ATRIAL F	1BRUCA	7/01	V				1 ☐ Yes	s 2 🗆 No	3 ☐ Pro	bably 4 Dunknown
Vital Records,	s been si should	Completed	CORDINAMY	ANTER	V D	ICT	ASE			24a. Was an	24b	. Were auto	opsy findings available
Re	The lay te has age 2	mo		11100	,	(	1.2.			autopsy perform	ed?	prior to co death? 1 \sum Yes	ompletion of cause of
ital	yeicien: The la is certificate has director, page 2	0	25. Was case referred to medical					26. Place	of Death (C	1 ☐ Yes 2	) 100	1 1 1 1 1 1 1 1	21 No
>_	Phyeic this ce al direc	To B	examiner? 1 \( \sum \text{Yes}  2 \sum \text{No} \)	Hospital:	ent 2 EF	VOutpatien	t 3 DOA Ott	her: 4 D hurs	sing Home	5 Resider	nce 6 🗆 O	ther (Speci	fy)
Division of	or Attending Ph ifter death. Director: After th in by the funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 20 ay Year) 20	Bb. Time of Injury	28c. Inju	ry at	28d	. Describe how	w injury occu	ırred	
<u>S</u>	eath. eath. or: A the fu	Certification;	2 Accident investigation	on				Yes 2□N	lo				
Ξ	or Attencatter death Director: in by the	THE STATE OF	3 Suicide 6 Could not l 4 Homicide determined	1 28e. Place of in	jury - At hom- tc. (Specify)	e, farm, str	et, factory, office		28f.	Location (Street) City or Town,	eet and Nun State)	nber or Rur	al Route Number,
	pitel urs a srel C		200 Cartina A Constitution B										
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edicai	29a. Certifier 1 Certifying P (Check only one) Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination	∍age, death n and/or inv	occurred at the ti restigation, in my o	me, date and opinion, death	place, and h occurred a	aue to the car at the time, da	use(s) and n te and place	nanner as s , and due t	stated. o the cause(s)
	o the vithin o the omple	Med	29b. Signature and title of certifier	and mainer st			29c. Licens	se number		29	d. Date sign	ed (Month,	Day, Year)
	o de d		Mala.	11. 117	,	111	) 7	6	1515		7/-	-/.	1 (7)
5	FLA COY		30. Name and address of person who	completed cause of	death (Item 2	3a) (Typa	Print)	01	1113	-	1/2	5/0	6
9	. ()		M. THIMM MAY	HIPM 6	14 B	EACT	EXM	CHON7	- 1)/	SALI	SRUI	Y N	1D 21204
	Sta		31. Date filed (Month, Day, Year)		rar's Signatur	0	nell a	-141	21-	- Heart	/		
	Registr	ar	nn 2/8 Z	008	w B	6							

State of Maryland / Department of Health and Mental Hygiene

		•	For	rtificate of Death	Reg. N	2008 25691								
F	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death  Month	year 10:00a M								
	/Medic	al	Richard H. Mortimore	the City Taylor and accition of Double	7/23/2	Ic. County of Death								
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Annapolis		Anne Arundel								
<i>.</i>			Spa Creek Center  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday		8. Date of Birth	9. Birthplace (State or Foreign								
b	Funeral Director		203-10-9582 1X M 2□F 89 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	178/1919	PA <sup>untry)</sup>								
	land ow It		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits								
	Mary f sho ied a	ē	MD Anne Arundel Anna	polis		1 □Yes 🗶 No								
	the notif	rec	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?								
	3a or		1189 St. George Dr.	21409		USA								
	ems 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- po Rican, etc.)	14. Race - American Indian, Black, White, etc.								
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 □ Never Married 2√ Married 1√ X es 2 □ No WWII 1 et 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 <b>X</b> No Specify:		Specify: White								
21215-0036	"natu	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king   16b.	Kind of Business/Industry								
7	within ene. than	E C	Elementary/Secondary (0-12)   College (1-4or 5+)	Carpenter		Construction								
р Б	filed Hygi ther ther	ပ္	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maid	en Surname)								
Maryland	ld be ental <b>ked o</b> ic eve	To Be	Arthur Mason Mortimore	Emma M	IcGraw									
Ž	shound M	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Ru	ıral Route Number, Cit	y or Town, State, Zip Code)								
Š	alth a 27 is 27 is r tra		Rozella Mortimore Spouse 1189	St. George Dr. A	nnapolis,	MD 21409								
Je,	of Hear		20a. Method of Disposition  20b. Place of Disposition  20c. Place of Disposition	position (Name of ematory or other place)	Date 20c.	Location - City or Town, State								
E	Page nent ant: If ant: If			Veterans Cem 7/2										
Baltimore,	permit. Departr importa any inj			22. Name and Address of Facility Harles Ridgely Ave. A										
			23a. Part1. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between								
	Physician	9 0	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Dea											
1	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	wtery Dis										
	Examiner		Sequentially list conditions b. Covunary F	++tery Dis	ease									
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	-										
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last   C											
60,	icate be executed physician and s the burial-transit		but to (or as a sometycenes sy).											
68760,	physic the l	Medical	d											
	certific ding p		IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery								
Вох	leath cert attending	Physician/	in the past 12 months?  4 Pregnant at time of death	B□Ectopic pregnancy i□ Other (specify)		Month Day Year								
0	the c sy the	hysi	9 ☐ Unknown		_									
ري ص	res that the de signed by the a be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?								
ğ	w require been sig should b	pa	Hypertension,	A 1	1 Tes	2 No 3 Probably 4 Unknown								
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed	Dysphagia Chronic Ren	al Failure	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?								
ď	The lav	E			performed 1 Yes 2 🔀									
Vital		Be	25. Was case referred to medical examiner?	26. Place of De	ath (Check only one)									
or V	Physician: r this certificantal director, i	2	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat			e 6 □Other (Specify)								
n o			27. Manner of Death  1 → Hatural 5 □ Pending	/ Work?	28d. Describe how i	njury occurred								
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation	M 1 Yes 2 No	206 Leasting (Street	t and Number or Rural Route Number,								
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, S									
	To the Hospital or Attend within 24 hours after death.  To the Funeral Director: /		29a. Certifier  (Check only (Check only a Decide of Market)  29a. Certifier (Check only (Check only a Decide of Market)  29a. Certifier (Check only (C	ath occurred at the time, date and plac	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)								
	the H in 24 the Fi nplete	Medical	one) and manner stated.	29c, License number		Date signed (Month, Day, Year)								
	To the within To the comple	2	29b. Signature and title of certifier	The state of the s										
	Ala	W.	The state of the s	1006	7	1/424, 2003								
,	なび、シ	¥	30. Name and address of person who completed cause of death (Item 23a) (Typ	<sub>e, Print)</sub> 35 Milkshake Ln - A	nnanolic	MD 21403								
		ate	31. Date filed (Month, Day, Year) 32. Refistrar's Signature	TITINSHAKE LII A	uniahotts	<u>гш 2140J</u>								
	Regis		31. Date filed (Month, Day, Year) JUL 2 5 2008 32. Resistrar's Signature	1										

	1	eady Si	tate of Marylan	id / Departr	ment of icate of	Health and	Mental Hy	Reg.	200	8 2569							
Physicia		I. Decedent's Name (First, Midd		1				2. Date of Death  Month  D	ay Year	3. Time of Death 0343 hrs							
le " -al Examir		Roland Ways  4a. Facility Name (If not institution			4	b. City, Town, or Lo	ocation of Death	August 1, 20	4c. County of Death								
	н	24040 John Cameror	_	,		Hollywood			St. Mary's								
Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. last l	birthday)	If Under 1 Year		8. Date of Birth(	MM/DD/YYYY) 9. Birt Foreig	thplace (State or							
Director		215-52-9874	1 X M 2 F	59	Yrs	Months Days	Hours Min.	05/11/1	1949 Co	<sup>untry)</sup> Maryland							
	ļ	Usual Residence of Decedent		10c. City, To						10d. Inside City Limits							
ow any		10a. State 10b. County				IOII				1 Yes 2 X No							
r death with the Maryland or items 23a or 28a-f show must be notified at once.	iè	Maryland St. 1	Mary's	Hollyw	boot	10f. Zip Code		10g	Citizen of What Cou	Lntry?							
e Mar or 28,	Director					20636		11	nited Stat								
vith th		24040 John Cat 11. Mantal Status		dent Ever in U.S.		s Decedent of Hisp		ecify Yes or No-	14. Race - Amer	ican Indian, Black,							
leath v	Funeral	1 Never Married 2 X	Married Armed Ford	ces? 2 X No	If Y	es, specify Cuban,	Mexican, Puerto F	Rican, etc.)	White, etc.								
after c		3 Widowed 4 Di	ivorced If Yes, Give Year or Dates:			Yes 2 X No				ite							
hours natur Exam	edt	15. Decedent's Education (Sp			Sa. Deceder during m	nt's Usual Occupation ost of working life. I	on (Give kind of we DO NOT use retire	ork done 1 ed)	6b. Kind of Business/	Industry							
36 in 72 han " dical	plet	Elementary/Secondary (0-12 $10$	College (1-4		Fruck	Driver			Constructi	on							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	17. Father's Name (First, Middle	e, Last)	·	LIUCK		8.Mother's Name										
215 be file ntal Hi rked o	a	John Robert S					Dorothy 1										
21 nould is ma	٩	19a. Informant's Name/Relation							er, City or Town, State	e, Zip Code)							
MC nd 2 sl afth ar m 27		Elizabeth McC: 20a. Method of Disposition	ready/Wife	20h Pia	24040	John Car sition (Name of cem	neron Way	y, Holly	wood, MD 20c. Location - City or	20636 Town, State							
Ore, es la of He If ite		1 Burial 2 X Crematic	on 3 Removal from	m State cre	matory or ot	her place)											
timent rtant:		4 Donation 5 Other		Brin					Charlotte								
Bal Bermi Depar Impo injur		21. Signature of Funeral Service Licensee  Shawn Aylesworth M01521  22. Name and Address of Facility Brinsfield Funeral Ho 22955 Hollywood Road, Leonardtown, M															
Physician	$\exists$	23a. Part I. Enter the disease,	or complications that car	used the death. D	o not enter t	the mode of dying, s	such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and							
Medical																	
_xaminer		or condition resulting in death)	Due to (or as a c	consequence of):													
	La	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence of):													
	mine	cause. Enter Underlying Caus (Disease or injury that initiated	e e		8		72.00										
ed nsit	Exa	events resulting in death) Last	t Due to (or as a	consequence of):													
execution and and and and and	cal	X UNPENDED	d. AMENDED 2	3a,27,28	3a−t,	perME, g	882 8/12	/08 TT									
iox 68760, eath certificate be executed a attending physician and for use as the burial - transi	sician/Medical	IF FEMALE:	23c. If yes, c	utcome of pregna	ncy				23d. Date of delive	гу							
Box 68760, e death certificate but the attending physic ed for use as the bur	an/l	23b. Was decedent pregnant in past 12 months?	the 1 Live bit	rth	2 F	etal death 3	Ectopic pregna	ncy	Month	Day Year							
OX (eath ce	sici	1 Yes 2 No 9 U	Jnknown g Unknow	ant at time of deat wn	n 5 0	ther (Specify)			1								
D. B t the de by the	Phys	Part II. Other significant cond			ulting in the	underlying cause g	iven in Part I.	23e. Did tob	acco use contribute to	o the cause of death?							
P.C es tha igned be det	d by							1 Yes	2 No 3 Pro	obably 4 V Unknown							
rds, requir been s	Completed							24a. Was ai autops		autopsy findings available completion of cause of							
SCO ie law te has ge 2 sl	dmo							perform	ned? death?								
I Re n: Th rtifficar tor, pa	e C	25. Was case referred to medi	cal			26.Place	of Death (Check	only one)									
Vita tysicia this ce direct	0 B	examiner? 1 ✓ Yes 2 No	Hospital: 1 lr	npatient 2 E	R/Outpatier	nt 3 DOA	Other Nursin	ig Home 5 F	Residence 6 🗸 Oth	er: Scene							
	n: T	27. Manner of Death		of Injury 2 Day,Year)	28b. Time of		ry at Work?	28d. Describe h	ow injury occurred								
of ing P After Unerr	atic				Fnd 3:	35 am -	res 2X No		troot and Number or F	Pural Poute Number City							
sion of ttending P death. ctor: After y the funers	: "		ould not be	_	ne, farm, str	eet, factory, office b	7	or Town, St. Hollywoo	ate) 2404 Joh	Rural Route Number, City nn Cameron V							
Division of all or Attending Patter death.  I Director: After d in by the funers	rtifica		etermined (Specify)	house						-1							
Division of Vital Records, P.O. ospital or Attending Physician: The law requires that the hours after death.  Incurs after death.  Incurs a Director: After this certificate has been signed by by filled in by the funeral director, page 2 should be detach.	Certification:	4 Homicide		t of my knowledge	death acc	urred at the time de	ate and nlace, and	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
Division of the Hospital or Attending Phin 24 hours after death. The Frences Director: After appletely filled in by the funeral		29a. Certifier 1 Certifying	Physician: To the best	of examination and	e, death occi d/or investig	urred at the time, da ation, in my opinion	ate and place, and , death occurred a	i due to the cause at the time, date a	e(s) and manner as stand and place, and due to	ated. the cause(s)							
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after during the search of the To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Certifica	29a. Certifier 1 Certifying	Physician: To the besi xaminer:On the basis of and manner st	of examination and	e, death occi d/or investig	urred at the time, da ation, in my opinion 29c. Licens	, death occurred a	at the time, date a	e(s) and manner as stand place, and due to 29d. Date signed (M	the cause(s)							
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral		29a. Certifier 1 Certifying one) 2 Medical E	Physician: To the besi xaminer:On the basis of and manner st	of examination and	e, death occi d/or investig	ation, in my opinion	e number	due to the cause	nd place, and due to	the cause(s)  fonth, Day, Year)							

State Registrar 31. Date filed (Month, Flav, Year) 2008

ORIGINAL

Physician Medical Examiner    1. December Name (First Midde, Last)   DATSY B. NICHOLSON   2. Date or Committee and number)   2. Date or Committee and number)   4b. City, Town or Location of Death Examiner   1. December 1. Date of	ame	na <sub>II</sub> Z	,	7/29/08 CCHPlea  1 - State Registrar	State o	f Marylan	d / Depa	artment	of H	ealth a	and M	lental H	ygien	e <sub>2</sub> n	08	25	693
SCORD HORSE TEAL  INTO INSECTION  UNION INSCRIPTION  UNION INSCRIPTION  UNION INSCRIPTION  INSCR				1. Decedent's Name (First, Middle		OLSON	- Cei	lincate	OIL			Month	eath		Year	3. Time of	Death
United Residence of Discolated   100. Colory   100. City, Town or Location   100. City, Town or Location   100. City   100. City, Town or Location   100. City				· · · ·	-	mber)		4b. City, To			of Death		4	·			
State   100 Courty			•		-					24 Hrs. Min.	8. Date of B (Month, I JUNE 2	irth Pay, Yea	1910	Coun	try)		
ELIJAH NICHOLSON  EDITH DUKES  1 St. Informant's Name-fleationship (Type. Print)  1 St. Mailing Address (Street and Number or Plausif Racide Number, City or Town, State, Zip Code)  1 St. Informant's Name-fleationship (Type. Print)  1 St. Mailing Address (Street and Number or Plausif Racide Number, City or Town, State, Zip Code)  1 St. Informant's Name-fleationship (Type. Print)  1 St. Mailing Address (Street and Number or Plausif Racide Number, City or Town, State, Zip Code)  1 St. Informant's Name-fleationship (Type. Print)  2 St. Manual or Plausification (Plausification Number, City or Town, State, Zip Code)  1 St. Informant's Name-fleationship (Type. Print)  2 St. Manual or Plausification (Plausification Number, City or Town, State, Zip Code)  1 St. Informant's Name-fleationship (Type. Print)  2 St. Manual or Plausification (Plausification Number, City or Town, State, Zip Code)  2 St. Part I. Enter the residence, Lor competitions of Code of Plausification (Plausification Number, City or Town, State, Zip Code)  2 St. Part I. Enter the residence of St. Information (Plausification Number of Plausification Number of Plausification Number of Plausification (Plausification Number of Plausification Number	1215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	10a. State 10b. County  MARYLAND CI  10e. Street and Number 100 LAUREI  11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Divorced  (Specify only higher Elementary/Secondary (0-12)	DRIVE  12. Was Dece Armed For 1 Tyes If Yes, Given Year or D.  13. Was Dece Armed For 1 Tyes, Given Year or D.  14. Was Dece Armed For 1 Tyes, Given Year or D.  15. Was Dece Armed For 1 Tyes, Given Year or D.	edent Ever in U. rces? 2X No vee atles:	.S. 13.	FIL  10f. Zip C  Was Decede If Yes, specify  1 Yes 2 dent's Usual & kind of work DO NOT use	219 nt of Hi y Cuba No Occupa	21 spanic On n, Mexical Specify:	:		16b.	14. Race Black Specify Kind of Bu	Vhat Coun USA e - Americ k, White, BLAC siness/Ind	1 XYes  an Indian, etc.  K  dustry	
Special Part   Spec	yland 2	tould be filed to a Mental Hygid	Be	17. Father's Name (First, Middle, ELIJAH NICHOLS	SON					ED.	ITH D	UKES	e, Maide	en Surnam	e)		
Physician Medical Examiner  23a. Part : Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardad or respiratory arrest.  Approximate the physician in the case of the cause of th		jes 1 and 2 st of Health and if Item 27 is π or other traum		GERTRUDE HAWKIN	NS / SISTE	20b. F	103	GEORGE	$\alpha$	URT,	HAVE	E DE C	RAC	E, MA	RYLA	ND 210	78
Physician / Medical Examinor    Physician / Medical Examinor   Medical	Baltim	permit. Pag Department Important: I any Injury o once.		4 □ Donation 5 □ Other (S	Specify)	F		2. Name and . LISA	Addres	s of Facili	ity FUNER	RAL HON	Œ, ]	P.A.			
The state of the s	RT 0	/Medical Examiner un and inal-transit	_	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	ASPIR (or as a conseq (or as a conseq AOVA	uence of):	ter the mode	of dyin	g, such as	s cardiac c	or respiratory	arrest,			Approximate Interval Bety	e ween
NC4272 20 1 20 1 20	. Box	he death certiff the attending thed for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live t	oirth 2 Feta nant at time of d	al death 3[							1		*	/ear
NC11772		equires that t sen signed by ould be detac	by	Part II. Other significant condit	ions contributing to de	eath but not res	ulting in the u	underlying cau	se give	en in Part I	l.			-			
NC11772		n: The law fficate has b or, page 2 sh		25. Was case referred to medical						00 Pl-		aut pei 1∐ Yes	formed 2	۶ - ۱	death?		available ause of
NC11772 21 21 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Division or Vi	ai or Attending Physicia s after death. Il Director; After this cert d in by the funeral directs	ို	examiner?  1 Yes? 27 Manner of Death Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	Hospital: 1  28a. Date (Mon igation not be 28e. Place	of Injury th, Day Year)	28b. Time of Injury	of 280	injur Worl	y at	weing Ho	me_ 5 ☐ Re 28d. Describ 28f. Location	sidence e how in	jury occurr	red		ıber,
1 / Item   D54073   28 Jul 08		To the Hospit within 24 hours To the Funers completely fille		(Check only 2  Medica one)	Examiner: On the b	asis of examina	owledge, deal ation and/or in	nvestigation, i	n my o	pinion, de e number	eath occur	and due to the time	e, date a	and place, Date signe	and due to	o the cause(s	.)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  2 Arlen Stone , ms 817 citrecitms Con New C457 LE DE 19720		2.		A	who completed caus			, Print)				4571E					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 July 24, **Physician** 9:05 AM Charles Nastav /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Alfred House-Assisted Living ROCKVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 7, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 № M 2 🗆 F Yrs. 197-09-2370 90 1917 Pennsylvania Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Wedical Eval. The court by confined at 1 ☐Yes 2X No Director Maryland Montgomery Montgomery Village 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20720 Highland Hall Drive 20886 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 72 hours after XYes 2□No World 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: War II 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry
Department of 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Defense Petroleum Specialist Pages 1 and 2 should be filed vent of Health and Mental Hygin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental George Nastav Barbara Mavretic ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other tra once. 20720 Highland Hall Drive, Montgomery Village, Antoinette Marquez (Daughter) altimore. 20b. Place of Disposition (Name of competery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State July 25 2008 4 ☐ Donation 5 ☐ Other (Specify) Crematory Alexandria, Virginia DeVol Funeral Home, 21. Signature of Funeral Service L 22. Name and Address of Facility 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. En . the usea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or like first fillers. List only one cause on each line.

Immediate Carse Approximate Interval Between Onset and Death **Physician** Renal Tumor years disease of ndition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lie accordingly), that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transi be executed resulting in death) Last Due to (or as a consequence of): O. Box 68760 Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 H Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Assisted
(Snecify) Living Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Certification: Division 1x Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20148 スイ July 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Dolinsky, M.D., 911 Russell Avenue, Gaithersburg, MD 20877 31. Date filed (Month, Day, Year) Registrar's Signature State 28 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JMTy 22,2008 3. Time of Death 9:40pm **Physician** Daisy S. Norris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville National Lutheran Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🗓 F Sept 12,1918 Louisiana **Director** 89 218 54-5850 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or from any injury or other traumatic event 10d. Inside City Limits 10a, State 10c. City, Town or Location 1X Yes 2 □ No Funeral Director Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20814 5602 Durbin Rd 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 N9-43 If Yes, Give Year or Dates: 2-46 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑ No Specify: Specify: White þ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Interior Designer Sloans 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maude Marshal Thomas J. Spurlock ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnstone Quinan/Brother-In-Law 2900 Johnson Dr., Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1<sup>™</sup> Burial 2 □ Cremation 3 <sup>™</sup>Removal from State Arlington National Cem 9-29-08 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause aset and Death Immediate Cause (Final disease or condition resulting in death) months **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a or Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 Yes 2 1 No 4 Nursing Home 5 Residence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760.

Coureth

License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles W. Keresh, M.D. 9701 Veirs Dr., Rockville, MD 20850

State Registrar

Medical

29a. Certifie

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 28 JUL 2008



State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 24, 2008 6:00 P M July Norton Sophie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Great Mills Saint Marys 45664 Edge Mill Court If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 8. Date of Birth (Month, Day, lug. 1, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Massachusetts 76 Yrs Aug. Director 026-22-0226 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examine items be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 No Director Maryland Saint Marys Great Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20634 Funeral 45664 Edge Mill Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2√∑No Specify. þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Registry of Elementary/Secondary (0-12) College (1-4or 5+) Senior Clerk 12 Motor Vehicles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Costa D. Cronopulos မ Maria Drugas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Norton, Sr. (Husband) 45664 Edge Mill Ct., Great Mills, MD 20634 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 N Burial 2 ☐ Cremation 3 N Removal from State 7/29/08 5 ☐ Other (Specify) Gethsemane Cemetery Boston, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Faggas Funeral Home 551 Mt. Auburn St., Watertown, MA 02472 Louen 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Endometrial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha 2 🛛 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No reral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe July 25, 2008 DO067594 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEPP IND, Cheryl Hospital Road Prince Frederick, 100 31. Date filed (Month, Day, Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registra

28

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 25697 For State Registrar, AMEND#23a(a)perMD 7-28-08, BMW, Moob Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 22, Day 3:30 2008 an 0100 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Nursing and Rehab Center Rockville, MD Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🖺 F Hours 219-06-7894 96 Dec 24, 1911 Iran Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14900 Talking Rock Court 20878 Iran Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 22 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify White Specify: 3XXVidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Sakineh Noroozian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Director þ Completed

Be

10a. State

MD

Abbas Khamsei

19a. Informant's Name/Relationship (Type. Print)

1 and 2 should be filed within 72 hours after death with the Maryland rheath and Mental hygiene.
3m 27 is marked other than "natural", or items 23a or 28a-f show or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Ith and Mental Hygiene.
27 is marked other than ' .. Pages 1 and arthur the result of Health ar = 5 permit. Page Department of Important: If any Injury or once.

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Physician /Medical Examiner

requires that the death certificate be executed

or Attending Physician:

To the Hospital within 24 hours a

this

ours after death.
neral Director: A

29a. Certifier

(Check only

29b. Signature and title of certifier

Dr. Weihan Wang

JUL

25

31. Date filed (Month, Day, Year)

Medical

Division or Vital Records, P.O. Box 68760,

use as the burial-trag Physician/Modical signed by the and be detached for 2 page B funeral

	Mansoureh Pirnia	(daughter)	14900 Talkir	ng Rock Ct.	Gaithersb	urg, MD 20878	
	20a. Method of Disposition	20b. Pla	ace of Disposition (Name of	of i		Location - City or Town, State	
	1 ABuriat 2 □ Cremation 3 D 4 □ Donation 5 □ Other (Specia	Memoval from State	1 Memorial F		/2008 Fali	ls Church, VA	
	21. Signature of Funeral Service Lice	nsee	22. Name and A	ddress of Facility	· · · · ·	2204	42
	But of you	CC0458	Nat'1 Fu	meral Home	7482 Lee 1	Hwy Falls Churc	ch, VA
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death, one cause on each line.  a.  Due to (or as a conseque	ulmonary Ari	dying, such as cardiac	or respiratory arrest,	Approxima Interval Be Onset and	etween
		cong		est faile	ire		
<u>ט</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse ue	ence of):	1			
	Cause. Enter Underlying Cause (Disease or injury that initiated events	Chron	nic Kidem	diseas	le.		
alcai Lyc	resulting in death) Last	Due to (or as a conseque	foot ga	ngrene			
y stellar min	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 □Ectopic pregn			23d. Date of delivery Month Day	Year
	Part II. Other significant conditions	contributing to death but not result	ting in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to the cause of	death?
3					1 ☐ Yes	2 No 3 Probably <b>火</b> □	Unknown
Series Series					24a. Was an autopsy performed? 1  Yes 2 ☑ N	24b. Were autopsy findings prior to completion of death? Io 1 □ Yes 2 □ No	available cause of
	25. Was case referred to medical examiner?			26. Place of Deati	h (Check only one)		
	1 ☐ Yes 2 🛣 No		R/Outpatient 3 DOA	Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Specify)	
	27. Manner of Death 1 ऄ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	28b. Time of 28c. Injury	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
	3 Suicide 6 Could not be determined	28e. Place of injury - At hom building, etc. (Specify)	ne, farm, street, factory, off	fice	28f. Location (Street a City or Town, Sta	and Number or Rural Route Nu te)	nber,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DOO

29d. Date signed (Month, Day, Year)

State Registrar 9701 Medical Center Drive Rockville, MD 20850

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32.

**Registrar's Signature** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / D	Certificate of E			Reg. No. 2	800	25698					
	Physicia	ın	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	Day	Year	3. Time of Death					
	/Medic	al	Richard Allen O'Neal		I	7	13	80	1157 M					
	Examin	er	4a. Facility Name (If not institution, give street and number) 207 Wall Street	4b. City, Town, or				nty of Death						
ang or 2	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	Salisbu	If Under 24 Hrs.	8. Date of Bir (Month, Da		omico 9. Birth	place (State or Foreign					
	Director		221-72-3907	rs. Months Days	Hours Min.	June 14			rida					
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location					10d. Inside City Limits					
	Maryk f sho	ō							1 □ Yes 2 ဩNo					
	r 28a-	Director	DE. Sussex Laure1  10e. Street and Number	10f. Zip Code			10g. Citizen o	of What Cou	ntry?					
	h with	alD	33098 Bi-State BLVD	19956	5		USA							
	ems :	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No	)- 14. R	Race - Americal						
215-0036	J within 72 hours after death with the Maryland jene. I than "natural", or Items 23a or 28a-f show I're Madical Examinar must be rediffed at	ρ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 □Yes 2 No	Specify:		Spec		White					
<u>ဂ</u>	72 ho	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupa	ation Juring most of work	ina	16b. Kind of	Business/In	idustry					
121	filed within 72 Hygiene. other than "nal snt, I'c Medic	mp	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done di life. DO NOT use retired)										
Z	be filed v ntal Hygie od other t event, In	e Co	12 T	ruck Driver	18. Mother's Nam	e (First. Middle		cking						
yland	~ = 0 2	To Be	Donald O'Neal		Corrine			,						
<u></u>	shoul and M amar umati	F		Mailing Address (Street a				vn, State, Zi	p Code)					
, Mar	and 2 salth a 27 is er tra		Donna Rae O'Neal (Wife) 28	901 Seaford	Road Lau	rel, De	laware	19956	ó					
saltimore,	jes 1 ar of He if item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of cemeter.	Disposition (Name of y, crematory or other place	e) :	Date	20c. Locatio	n - City or To	own, State					
	t. Pag tment tant: jury o		4 ☐ Donation 5 ☐ Other (Specify) Odd F	ellows Cem.		-2008	Laure							
n n	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	22. Name and Address Hannigan, Sh	•	aroon F			t Street De. 19956					
			23a, Part 1. Enter the disease, or complications that caused the death. Do n						Approximate Interval Between					
1	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a											
	/Medical Examiner		resulting in death)  Due to (or as a consequence of	f):	)									
	Exammer	_	Sequentially list conditions, b.	Α).										
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	1).										
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last C	f):										
68/60,	ite be iysicia ie bur	cal	d											
20	rtifica ng ph	Medi	IF FEMALE:											
X P P	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy	,			Date of deliv Month	very Dav Year					
- 5	he de	Physician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)				W. Carlotte	Day tou.					
<u>.</u>	that t	/ Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	n in Part I.	23e. Did t	tobacco use co	ontribute to t	the cause of death?					
ecoras,	quires n sigr ald be	d by				1 🗆	Yes 2 No	3 □ Pro	bably 4 🗆 Unknown					
ပ္သ	aw rec	Completed				24a. Was		b. Were auto	opsy findings available					
ř	The la	lmo				auto perfo 1 □ Yes	rmed?	death?	ompletion of cause of					
VITal	ctor, p	BeC	25. Was case referred to medical examiner?		26. Place of Deat			, , , ,						
о Б	hysic this co al dire	၉	1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Out		4 LI Nursing Ho				ífy)					
	ting F	io	Thatalar Sharing	njury Work	?	28d. Describe	. ,	urred						
UNISION	Attend death ctor: y the	ficat	6 Could not be		res 2 Man	28f. Location (	)	mber or Bur	ral Route Number,					
<u>≥</u>	al or A after Direction b	Certification:	4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	00 W		City or To	wn. State)	alisma						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	, death occurred at the tim	ne, date and place pinion, death occur	and due to the	cause(s) and	manner as	stated.					
	Fo the within Fo the complex c	Me	29b. Signature and title of certifie	29c. License	number		29d. Date sig		, Day, Year)					
			) ( Stud ) I)ME	H5	7940		7/14/	08						
1	E MP		30 Name and address of person who completed cause of death (Item 23a) ( 100 ECQ 101)  31. Date filed (Month, Day, Year)  32. egistrar's Signature	Type, Print)	15 buru	w	2180	)]						
	Sta	te	31. Date filed (Month, Day, Year) 32. registrar's Signature	da de	1									
	Registra	ar	1111 2:8 2008	1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jacob Harry PAUL **Physician** 22 1:25 P July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Min Director 112-18-5314 83 May 9, 1925 New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exacting must be notified at 1 XYes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 1799 E. Jefferson Street #208 10g. Citizen of What Country? ō 20852 United States items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ٥ 1 ☐ Yes 2 X☐ No Specify: à Specify: White 3 1 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than 'r traumatic event, the Me than College (1-4or 5+) Etementary/Secondary (0-12) 0wner Men's Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Philip Paul Molly Itzkovsky ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Baraf, Daughter 5350 Edgemoor Lane, Bethesda, MD permit. Pages 1 and Department of Heath Important: If item 27 any injury or other tr once. 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 X Removal from State Anshe Sfard Cemetery | 07/25/08 4 ☐ Donation 5 ☐ Other (Specify) Akron, OH Juneral Service Licensee Torchinsky Hebrew Funeral Home Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LEVENTO JOSEA /Medical Due to (or as a consequence of) Examiner Nutmonja Schemas y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical JE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown s certificate has b irector, page 2 st 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title; 29c. License number 29d. Date signed (Month, Day, Year) 1041 170061302 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rohatgi, M.D., 8600 Old Georgetown Road, Bethesda, MD 20814

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

25

2008

32 Registrar's Signature

			1 - State Amend It	emš 23a, 1	25 per me	epartment of 19882 08/00 Certificate of	8/08dhb Death	noman m	Reg. No.		
	Physici	an	Decedent's Name (First, Middle, Last Louis Jones	st)				2. Date of D Month	eath Day	Year	3. Time of Death
	/Media	al		street and number		Ab City Town o	r Location of Death	April		08 unty of Death	10:00 рм
	Examir	er	4a. Facility Name (If not institution, give								
	Funeral		Layhill Genesis I  5. Social Security Number 6. S	ex 7. Aç	me e (In yrs. last birth		If Under 24 Hrs.	8. Date of B	irth	tgomer:	y blace (State or Foreign htry)
	Director		224-14-4509	☐M 2□F	85 Y	rs. Months Days	Hours Min.	May 11			
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					0d. Inside City Limits
	Maryl f sho	ļo			Silver	Spring					1 ☐ Yes 2√ No
	r 288	Director	Maryland Montgome: 10e. Street and Number	cy .		10f. Zip Code			10g. Citizer	of What Cour	ntry?
	72 hours after death with the Maryland naturel', or teme 23a or 28a-f show disal Examiner must be notified at		3227 Bel Pre Road			20906	5		United	States	3
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or N Rican, etc.)	14.	Race - Americ Black, White,	
36	s afte , or It	by Fu	1√ Never Married 2 Married 3 Widowed 4 Divorced	1 TYes 2 1 If Yes, Give Year or Dates:	No WWII	1 ☐ Yes 2 ☐ No	Specify:		Sp	pecify: B1a	ack
8	2 hour	edt	15. Decedent's Ed	lucation	16a. I	Decedent's Usual Occup	pation		16b. Kind	of Business/Inc	
215	within 72 ene. than "na	Completed	(Specify only highest gra	de completed) College (1-4or	5±1 I	Give kind of work done life. DO NOT use retired	during most of work d)	ting			
2	filed wit Hygien other tha	Con	Unknown		Mac	hinist				Naval Y	lard —
Maryland 21215-0036	d a b	Be	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Nam Unknov		e, Maiden Su	mame)	
ž	should be nd Mental marked o	۴	19a. Informant's Name/Relationship	Tyna Print)	19h	Mailing Address (Street			ber City or Tr	nwn State Zin	Codel 20050
	th and 2 should the and 27 is m		Donna Klein-Guar	*		1 Hungerfor					
ē,	is 1 and 2 if Health Item 27 other tra		20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other place		Date	,	tion - City or To	
Ë	Page ment o tant: If jury or		1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)			Lincoln Cre	m. Mav	9. 200	8 Bren	twood.	NO
Baltimore,	permit. Pages: Depertment of timportant: if ite eny injury or of		21. Signature of Funeral Service Liber	see	, 1012	22. Name and Addre	ss of Facility Sin	nple Tr	ibute	L. C. C. C.	
	90 E 9 9		" Curty Wok-	Medy		1040 Rocky	ville Pike	e, KUck	ville,	MD 208	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	the death. Do no ne.	ot enter the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ge Demen						
	Examiner			· ·	a consequence of	,		7	1/1		
		ler	Sequentially list conditions, if any, reading to immediate	b. Seizure	DISOIGE	r).	1	- 1	CAL EXAM	MER	
	cuted	Examiner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	c Coronar	Artery	Disease	CERTIFIC	A POROVED BY	WEDIO		
<u>,</u>	e exe	EX	resulting in death) Last	Due to (or as	a consequence of	f):	CERTIFIC				
68760,	tificate be executed ig physicien and as the burial-transit	edicai		d							
			IF FEMALE:	23c. If yes, outcome	of pregnancy				224	L Data of dollar	200
Box	death cer e attendir id for use	Physician/N	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnancy 5 Other (specify)	y		230	I. Date of delive Month	Day Year
P.O.	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		_					
G,	s thei	by P	Part II. Other significant conditions of	ontributing to death t	out not resulting in	the underlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to the	he cause of death?
200	w requires to been signed should be	ted	Diabetes Mellitu	ıs				1	Yes 2□1	No 3∏Prob	ably 4 Unknown
Vital Records,	The law requires thet the ste has been signed by th bage 2 should be detache	Completed	H'I'N					24a. Wa auto	opsy	prior to co	opsy findings available impletion of cause of
<u>سے</u>		Con	Quadriplegia  25. Was case referred to medical	ie to Cerv	ical Spi	ne Stenosis	5		formed? 2 <b>X</b> No	death? 1 ☐ Yes	2□ No
Zit.	Phyelcien: The this certificate ral director, pag	Be	examiner?	Hospital:			26. Place of Deat		-0-		
o	Phy or this aral di	. To	1 XYes 2XNo 27. Manner of Death	1 ∐ Inpati 28a. Date of Inju (Month, Da	ent 2 ☐ ER/Out <sub>l</sub> iry 28b. Ti	me of 28c. Injur	ry at	ome 5 ☐ Res 28d. Describe			y)
O	Attending r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation		y Year) In	jury Woi	rk?  Yes 2 □ No				
Division	ar des	Certification:	3 Suicide 6 Could not be determined	286. Place of In	ury - At home, fari c. (Specify)	m, street, factory, office		28f. Location	(Street and Nown, State)	lumber or Rura	al Route Number,
ō	ital or irs afte ral Dir led in			building, o							
	Phospital or Attend 24 hours after death Funeral Director: etely filled in by the	Medical	(Check only 2 Medical Exam	niner: On the basis of	f examination and	death occurred at the till for investigation, in my o	me, date and place, ppinion, death occur	and due to the	e cause(s) an e, date and pla	d manner as s ace, and due to	tated. the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	one) 29b. Signature and title of certifier	and manner st	ated.	29c. Licens				signed (Month,	
			) 40	-0		D006			04	1251	
1	-VK		30. Name and address of person who	completed cause of	death (Item 23a) (1					1 1	
			Farzana Ajmal, M.			Road; Silve	er Spring,	MD 2	0906		
	Sta		31. Date filed (Month, Day, Year)	32 Regist	orla Cianatura						
	Registi	ar	MAY 0 8 200	18	15 p	porte					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Glate of	iviai yiai i			of Death	a wientai in	Reg. No. 2	800	2570
	Physici /Medic		Dona     Dona	st) ild William	n Phillip	s			2. Date of Do Month	Day	Ye ar	3. Time of Death  2525 P M
	Examin		4a. Facility Name (If not institution, give	e street and numb	ber)		4b. City, Tov	vn, or Location of D	eath /	4c. Coun	ty of Death	
			Doctors' Commun					Lanham				George's
- 1	Funeral Director		5. Social Security Number 6. S 194-40-2530	Sex 7 ■ M 2□F	. Age (In yrs. la <b>59</b>	st birthday) Yrs.	If Under 1 Y Months D		lin. (Month, D	rth <i>ay, Year)</i> <b>8, 1949</b>	Count	ace (State or Foreign ry) <b>ylvania</b>
	pu ,		Usual Residence of Decedent		10-07-	Town on Lor					140	d. Inside City Limits
	hours after death with the Maryland tural", or items 23a or 28a-f show	ctor	10a. State 10b. County  Maryland Prince	George's	10c. City	, Town or Lo	cation	College I	ark			1 □Yes 2 No
	th the	ire	10e. Street and Number				10f. Zip Co	de		10g. Citizen o	f What Count	ry?
O	th wit	al	9014 Rhode Isla	nd Avenue				20740			U.S.A.	•
2	ter death with items 23a or	ner	11. Marital Status	12. Was Deced		i. 13. V	Vas Deceden	t of Hispanic Origin' Cuban, Mexican, P	(Specify Yes or Nuerto Bican, etc.)	o- 14. R	ace - America	
5 n a i	irs after il", or ite	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 □Yes 2 If Yes, Give Year or Date	X No		☐Yes 2 🗷		30,10 (110411, 010.)	Spec	14	hite
1) Don 215-0036	72 "na	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	Ī	16a. Deced	ent's Usual C	occupation lone during most of etired)	working	16b. Kind of	Business/Ind	ustry
212	be filed within 72 hortal Hygiene. id other than "natu event, Ib. Mydeal	Somp	Elementary/Secondary (0-12)	College (1-4	for 5+)	me. L		mal Care		u.s	. Govern	ment
S D	e filed al Hygi I other vent, I	Be (	17. Father's Name (First, Middle, Last	)				18. Mother's	Name (First, Middle	e, Maiden Surna	ame)	
Maryland	should be f and Mental I s marked ol	인	Frank T. Ph	illips					Vivian De	eMarco		
ar	2 sho 1 and is ma		19a. Informant's Name/Relationship (	Type. Print)		19b. Mailin	g Address (S	treet and Number o	r Rural Route Numi	ber, City or Tow	n, State, Zip	Code)
	and 2 n 27 ner tr		Frank A. Phillips	- Brother				ane, Silver				
Py Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than any Injury or other traumatic event, In Monce.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐		ale		sition (Name and atory or othe	i	Date	20c. Location	•	
垂	artme artme ortan Injury		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Per ice Lice)	-	Park		morial I Name and A	ddress of Facility	//28/2008	KOCKV1	lle, Man	ryland
Ba	Dep Imp		Daniel N	Ronk	ann	H	ines-Rir	naldi Funera Hampshire	1 Home, Inc	C. Iver Spri	no Mary	zland 20904
b	Physician /Medical Examiner	ler	23a Part 1. Eyter the disease, or come hock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause the cause (Disease or injury that initiated events	a. Car Due to (or	used the death ch line. rdiac Arr r as a consequence on ary Arr r as a consequence as a consequence of the death	est ence of): tery Di		f dying, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
1	uted d ansit	퉅	Cause (Disease or injury	Hyp	ertensio	n						
<u>~</u>	exec in and ial-tra	Examiner	resulting in death) Last	Ų	r as a consequ							· · · · · · · · · · · · · · · · · · ·
68760,	ificate be executed physician and s the burial-transit	Medical		d. Mor	bid Obes	ity						
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Fetal ant at time of de	death 3 □	] Ectopic preg ] Other <i>(speci</i>				Date of delive Month	ry Day Year
<u>s</u> .	es that igned b	by Pł	Part II. Other significant conditions	contributing to dea	th but not resu	Iting in the ur	derlyi <b>n</b> g caus	e given in Part I.				e cause of death?
P. O	w requires is been signishould be	ted							1	Yes 2∐No	3∐ Proba	abiy 4 🔀 Unknown
Division of Vital Records,	ician: The law r certificate has bu ector, page 2 sh	e Completed	25. Was case referred to medical					26 Place of	perf	ormed? 2 🗷 No	prior to con death? 1 □ Yes	osy findings available npletion of cause of 2 □ No
5	di S	o Be	examiner? 1 ☐ Yes 2 🗷 No	Hospital:	patient 2 🗆 E	ER/Outpatien	t 3 🗆 DOA	Othor	ng Home 5 ☐ Res		ther (Specific	·)
o o	ding Phys h. After this funeral di	۳: <u>۲</u>	27. Manner of Death	28a. Date of (Month		28b. Time of		Injury at Work?		how injury occi		<i>/</i>
<u>.</u> 5	nding ath. :: Aft	턇	1 X Natural 5  Pending 2  Accident investigatio		, Day, Year)	Injury	М	work? 1 ☐ Yes 2 ☐ No				
)ivis	or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place o building	of Injury - At hor g, etc. (Specify	me, farm, stre	eet, factory, of	fice	28f. Location City or To	(Street and Nur own, State)	mber or Rurai	Route Number,
	To the Hospital or Attendii within 24 hours after death.   To the Funeral Director: A completely filled in by the fu	Medical Ce		miner: On the bas	sis of examinat			the time, date and p my opinion, death				
	ithin (	Med	29b. Signature and title of certifier	and manne	si stateu.		29c. l	icense number		29d. Date sign	ned (Month. I	Day, Year)
	4	5	1///	-MO				64268	>		21/0	

State Registrar dress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008<sup>Ye ar</sup> July **Physician** 7:00A.M 21. Phillips Louis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 52-A Crescent Road Prince George's Greenbelt | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 30, 1939 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★M 2 ☐ F 579-50-1602 68 Washington, DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Inst. If item 27 is marked other than "natural", or items 23a or 28a-f show any or other tranmatic event, The Mental Armin or or other tranmatic event, The Mental Armin or or other tranmatic event, The Mental Armin or or other tranmatic event, The Mental Armin or or other tranmatic event, The Mental Armin or or other tranmatic event, The Mental Armin or other tranmatic event, The Mental Armin or other transfer or other t 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Marvland Prince George's Greenbelt 1 XYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 52-A Crescent Road 20770 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 □Yes 2 No Specify <u>Ş</u> Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Barber Barber Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillips Pete (unk) ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda E. Phillips -wife 52-A Crescent Road Greenbelt, Maryland 20770 permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr.
once. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 7/24/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen ee PA Parte and Address of Facility and Laneral Home, PA tun 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
1 hour Immediate Cause (Final Acute Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Carcinoma Prostate 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 1 □Yes 2 XNo Hospital or Attending Physiclan: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 XResidence 6 Other (Specify, 1∐ Yes 2∐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O.

To the Hospital within 24 hours a To the Funeral I

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Gabriel B. Jaffe, M.D. 7500 Hanover Parkway, #105 Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) 25 .1111. 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D16410

29d. Date signed (Month, Day, Year)

July 24, 2008

State of Maryland / Department of Health and Mental Hygiene 2008 25703 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 1. Decedent's Name (First, Middle.Last) 2. Date of Death Physician/ Month Day August 4, 2008 Year 1700 hrs Pettie Helen Elizabeth al Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Cumberland Allegany 10511 Christie Road 9. Birthplace (State or Foreign Maryland B. Date of Birth (MM/DD/YYY) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 08/23/1956 Director 215-68-5838 51 Country) 1 M 2X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Allegany Cumberland MD 28a-f shov once. the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number notified at USA 21502 10511 Christie Road 238 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married Married 2 X No Ves 1 Yes 2 X No specify: Specify White Divorced If Yes, Give Year hours after "natural", Examine þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "1 injury or other traumatic event, the Medical E Nursing Home Nursing Aid 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aldridge Pettie. Sr. Jeanette Walter Marv Charles Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 130 Polk Street, Apt 2, Cumberland, MD Baltimore, MD Brian Pettie / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition 849/2008 Davis Mem (Cemetery) 1 Burial 2 X Cremation 3 Removal from State Cumberland, MD Other Specify 22. Name and Address of Facility ams ami y unera ome, . . . Signature of Funeral Service Licensee 21502 404 Decatur Street, Cumberland, MD Approximate Interval I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician Between Onset and failure. List only one cause on each line. Medical Death a Narcotic and Tramadol Intoxication Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 20a-b, perFH 23a, PII, 27, 28a-f, perME, g882 8/13/08 TT ending physician a use as the burial -X UNPENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. P.O. Part II. Other significant conditions Yes 2 No 3 Probably 4 V Unknown Cocaine use Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has death? performed? page No 1 🗸 Yes Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 No this 1 🗸 Yes 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natura! Yes 2X No A Director: ed in by the f Pending 24 hours after death. Fnd 5:00 pm Fnd 8/6/082 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide or Town, State) 10511 Christie Rd. determined (Specify) Found: residence umberland, Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca within 2 To the F 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 5, 2008 ns mo O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD filed (Month, 32. Registrar's Signature Day 8 State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Inita Year Marie 2102 PM euss /Medical 2008 Juli 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Jashington Center Washington for Prince George 5. Social Security Number 8. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign
 Country) 818 1 □ M 2 1 F 165-40-Days Director Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "netural; or Iteme 23s or 28e-f show any injury or other traumatic event, the Madical Examinat is notified at once. 10d. Inside City Limits New DE Castle Bear Directo 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Dragon by Funerai USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Ed bailey Leah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of comptery, crematory or other place)
United Crematory
22 Name Husband Bear 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 01/24/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Family Funeral Home Strano + Feeling Family Funeral Home 635 Churchmans Road, Newark DE 19702 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atheros 10 usily levoti /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Completed by Physician/Medical been signed by the ettending physishould be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months2. 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day o page 2 should be detached 5 Other (specify) Year 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use coptfibute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown this certificate has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician; completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one | ို 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence SQther (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred -1 - Natural 5 Pending Iniun 2 Accident investigation within 24 hours after death To the Funeral Director: 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Livingston Rd, Fort Washington Narasimhan 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar JUL 2 9 2008 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2:30 P M 18, 2008 Ruth Iris Ruthvin July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Northampton Manor Nursing Center Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 21, 1922 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🐼 F 212-14-6893 86 Jan. Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified 1 X Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò be "natural", or items 23a 200 East 16th Street 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or iter any Injury or other traumatic event, the Medical Examiner 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 KNo Specify: White þ Specify 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier 12 Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Abrecht Wilmoth Adams 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cheryl King / Daughter 209 Moser Circle, Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven 20a. Method of Disposition Date 20c. Location - City or Town, State 22, 2008 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens Frederick, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the discrete, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filt re. List only one was en each line. Immediate Cause (Final disease or condition resulting in death) leura Physician weeling /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 1 ∐ Yes 2 No 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗖 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 22 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 412 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F after death. 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43091 7-21-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Toll House Ave, Frederich Cardi MD 801 31. Date filed (Month, Day, Year) 32. Redistrar's Signature Registrar

08-05927 Adelyn Ruggieri

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 25707

1- For State Registrar	Cer	tificate of Death	Reg. N	40.
Physician/ 1. Decedent's Name (First,	Middle,Last)		2. Date of Death Month Da	3. Time of Death
ledical Examiner Adelyn J.		4. 60. 7	August 2, 200	1910 hrs 4c. County of Death
4a. Facility Name (if not ins	titution, give street and number)	4b. City, Town, or Locati Laurel	ion of Death	Prince George's
Funeral 5. Social Security Number	6. Sex 7. Age (In yrs. la	ast birthday) If Under 1 Year If L	Under 24Hrs. 8. Date of Birth(N	MM/DD/YYYY) 9. Birthplace (State or
Director 367-22-5148  Usual Residence of Decedo	1 M 2XF 8	1 Yrs. Months Days He	ours Min. Aug. 14	4, 1926 Country) Michigan
10a. State 10b. Co		Town or Location		10d. Inside City Limits
Varyland P: Waryland P: Waryla	rince George's	Silver Spring_		1 Yes 2 X No
the Waryland P. Maryland P. 10e. Street and Number 10e. Street and Number 3144 Grack	rince George's efield Road, GV214	10f. Zip Code	090 <b>4</b>	Citizen of What Country? USA
Maryland  Pages 1 and 2 should be filed within 12 hours after death with the Maryland feet of Health and Marlell Hygical  In If Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In If Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland  In Itiem 21 and 2 should be filed within 12 hours after death with the Maryland Be filed within 12 hours after death with the Maryland Be filed within 12 hours after death with the Maryland Be filed within 12 hours after death with the Maryland Be filed within 12 hours after death within 12 hours after death within 12 hours after death within 12 hours after death within 12 hours after death within 12 hours after death within 12 hours after death within 12 hours after death within 12 hours after death within 12 hours after death within 12 hours after death within 12 hours after death within 12 hours after death with	Married 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 X No	S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi		14. Race - American Indian, Black, White, etc.
3 X Widowed 4	Divorced If Yes, Give Year or Dates:	1 Yes 2 XX No spe		Specify: White
15. Decedent's Education	(Specify only highest grade completed)	16a. Decedent's Usual Occupation (G during most of working life. DO N		b. Kind of Business/Industry
Pages 1 and 2 should be lifed within 72 hour ment of Health and Mental Hygiene.  The manuality event, the Medical Example of the manuality event, the manuality event of the	2	Postal Clerk		U.S. Postal Service
The street of th		18.Mc	other's Name (First, Middle, Maid  Mary Piotrows	
2727  Mental Januar ked  Nental Januar ked  Nental Januar ked  Description of the property of		19b. Mailing Address (Street and		
Rand P. Rue	ggieri/Son	9019 Woodland	Drive, Silver S	Spring, MD 20910
20a. Method of Disposition	20b. F	Place of Disposition (Name of cemetery crematory or other place)	·	Oc. Location - City or Town, State
E So to	Ar.	lington National	Aug. 20, 2008	Arlington, Virginia
Baltimore, MD 21215-003  Bealtimore, MD 21215-003  Bealtimore of Health and Montal Hygiene Department of Health and Montal Hygiene Department of Health and Montal Hygiene Important. If item 21 is marked other than matric event, the Med and Donation 5 Oth Stranger of Health and Donation 5 Oth 21. Signature of Funeral Stranger of Health and Dona		22. Name and Address of Fa Francis J. (	acility Collins Funeral	l Home Inc.
for the last the	se, or complications that caused the death.	500 Univers	ity Blvd, W., S	Silver Spring, MD 209
Medical  Kaminer  Medical  Kaminer  Medical  Medical  Medical  Medical  Medical  Model Cause (Final di  or condition resulting in de	cause on each line. sease a. <u>Hypertensive</u>	atherosclerotic c		Between Onset and
Sequentially list conditions	h			
if any, leading to immediate cause. Enter Underlying Cuisease or injury that initial events resulting in death.	e Due to (or as a consequence or Cause	f):		
B isi B		f):		
		perME, g882 8/20/0	08 TT	
physician he burnal he bur	23c. If yes, outcome of preg	nancy		23d. Date of delivery
Division of Vital Records, P.O. Box 683  To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the functal director, page 2 should be deached for use as the completely filled in by the functal director, page 2 should be deached for use as the formal director, page 2 should be deached for use as the formal page 2 should be deached for use as the formal page 3. A special page 4. A solution of the formal page 5. A should be deached for use as the formal page 6. A should be deached for use as the formal page 7. A solution of the formal pa	4 Pregnant at time of de	2	ctopic pregnancy	Month Day Year
A part II. Other significant (	Unknown  Sonditions contributing to death but not re	esulting in the underlying cause given i	in Part I. 23e. Did toba	cco use contribute to the cause of death?
Part II. Other significant of part A Part II. Other significant of part A Part II. Other significant of part A Part II. Other significant of part II. Other			1 Yes	2 No 3 Probably 4 Unknown
Division Of Vital Records,  Is a farted death.  In a farted death.			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
Vital Reco Sician: The law Piscertificate has director, page 2 s a examiner.  The law  Sician: The law			1 Yes 2	No 1 ✓ Yes 2 No
25. Was case referred to mexaminer?	Hoonital:	Othor	eath (Check only one)	-:J C Other
The property of the property o	o 28a. Date of Injury	ER/Outpatient 3 DOA Other  28b. Time of Injury 28c. Injury at V	· _ rearrants remit v _ res	sidence 6 Other:
tending ceath.  The function of the function o	(Month, Day,Year) Pending	1Yes 2		
Accident 2 Microsoft 2 Microso	Investigation Could not be 28e. Place of Injury - At he	ome, farm, street, factory, office buildin		et and Number or Rural Route Number, City
Division o Attending Spiral or Attending Spiral or Attending O Attending Spiral or Att	determined (Specify)		or Town, State	e) 
Division  To the Hospital or Arten  Within 24 hours after death  Within 24 hours after death  Within 24 hours after death  Wedical Certifical Certific  Completely filled in by the Check only  To the Function  Solution  A Homicide  Solution  To Certify  Concept only  To Medical  Solution  Solution  To Certify  Concept only  Solution  S	ing Physician: To the best of my knowled	ge, death occurred at the time, date an nd/or investigation, in my opinion, deat	nd place, and due to the cause(s th occurred at the time, date and	and manner as stated.  If place, and due to the cause(s)
≥ 29b. Signature and title of the	and manner stated.	29c. License num		9d. Date signed (Month, Day, Year)
Pamate 9	outhall, mo	O.C.M.E.	. A	August 3, 2008
30. Name and address of p	person who completed cause of death (Item all, MD Assistant Medical Exa		altimore, MD 21201	
1 1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Year) 32 Registrar's Signatu			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Month Year Leslie Samue1 Rogers July 24, 2008 1:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice- Casey House Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 3 M 2 ☐ F Months Days Director 235-94-5062 17, 1956 Alabama Nov. Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location show 10d. Inside City Limits a or 28a-f show 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Williamsburg Drive 20901 USA ral", or items 23a Examiner must b death v Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify Specify: \$ 3 Widowed 4 Divorced 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Montgomery County Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked ot Pages 1 and 2 should be ဥ Wiley Samuel Rogers Miriam Paula Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 I Linda V. Rogers/Wife 410 Williamsburg Drive, Silver Spring, MD 20901 permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other t other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 2 2008 25 1 ☐ Burial 2 Coremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature di Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Brain Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jiseas or injury) that injuried according to Due to (or as a consequence of): Examine requires that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f Division or Vital Records, P.O. 9□Unknown 9 Unknown been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1□ Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 2XNo 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA Hospice this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? al or Attending P safter death. Il Director: After i d in by the funera Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours aft To the Funeral D completely filled in 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64615 July 24, 2008 and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, MD 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 25 Registrar 2008

		1 - State of Maryland Registrar		artment of H tificate of D		R	leg. No. 2	8 25709		
Physic /Medi		1. Decedent's Name (First, Middle, Last)	2 cm	nesh		2. Date of Dear		3. Time of Death		
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of I	Death		
Funeral Director		The Johns Hopkins Hospital         5. Social Security Number       6. Sex       7. Age (In yrs. last)         138 04 3693       42	st birthday) . Yrs.	Baltimore If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08/14/	None (Year) 9	Birthplace (State or Foreign Country)  India		
		Usual Residence of Decedent				00/14/	1703	10d. Inside City Limits		
aryland show	<u>_</u>	10a. State 10b. County 10c. City,	Town or Loc	cation				1 Yes 2 No		
the Ma	Director	MD Howard Wood  10e. Street and Number	dstock	10f, Zip-Code		1	I0g. Citizen of Wha	t Country?		
with 3a or		2138 Turn berry Way		21163			United S	States		
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes Give		Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A	American Indian, White, etc.		
21215-0036 d within 72 hours aft giene. er than "natural", or the Medical Examir	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupi kind of work done of DO NOT use retired	ation luring most of work	ing	16b. Kind of Busin	Asian ness/Industry		
121 within	를	Elementary/Secondary (0-12) College (1-4 or 5+)		tware Eng.			Citiar	oup		
Hygie ant, th		17. Father's Name (First, Middle, Last)			18. Mother's Nam		Maiden Surname)			
ylan( ould be wental is arked o attic eve	To Be	Raman Muthuswamy			Jayalaks	hmi Sub	ramaniam			
Maryland of 2 should be file th and Mental Hy 27 is marked oth traumatic event	Ι.	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street a	and Number or Rur	al Route Numbe	er, City or Town, Sta	ite, Zip Code)		
e, M 1 and 2 Health em 27 inther tra		Ramesh Koovelimadhom/Husband		Turn ber		odstock	, MD 211			
		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	emetery, cren etro Cr	osition (Name of matory or other place rematory	7-26		Catonsvi.	•		
Baltimo permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee M010	44   41	2. Name and Address  112 Old C	наг Olumbia F	ike Ell	icott Cit	Family FH Inc. Ly, MD 21043  Approximate		
Physician		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	ard		g, such as cardiac	or respiratory ar	rest, _	Interval Between Onset and Death		
/Medical Examiner			ue to (or as a consequence of):							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indirect events).  Due to (or as a consequence of):						24 hours		
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68760, tificate be ex g physician as the buris	Aedical	d		1000			- 1			
BOX death cer e attendin	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of dead 9 ☐ Unknown	death 3 [	☐ Ectopic pregnance ☐ Other (specify)	/		23d. Date of Month			
cords, P.O. requires that the een signed by the hould be detach	þ	Part II. Other significant conditions contributing to death but not resu	underlying cause gi			d tobacco use contribute to the cause of death?  Yes 2 ⊠No 3 □ Probably 4 □ Unknow				
Re lav	Completed					24a. Was a autop perfor	sy priemed? dea	ore autopsy findings available or to completion of cause of ath?  Yes 2 \( \) No		
f Vital yslcian: Tr s certificate director, pa	Be	25. Was case referred to medical examiner?		Louis	26. Place of Deat	h (Check only or	ne)			
of Vita Physician: this certifica	2	1 ☐ Yes 2 ☑No Rospital: 1 ☑ Inpatient 2 ☐ E		nt 3 DOA Othe	4 - Nursing Ho		lence 6 Other			
	lion:	1 Natural 5 ☐ Pending (Month, Day Year)								
/iSi	ertifica	27. Manner or Death  1 X Natural  2 X Natural  1 X Natural  2 Natural  1 X Natural  2 Natural  1 X Natural  2 Natural  1 X Natural  2 Natural  1 X Natural  2 Natural  2 Natural  2 Natural  1 X Natural  2 Natural  2 Natural  2 Natural  2 Natural  2 Natural  2 Natural  2 Natural  2 Natural  2 Natural  2 Natural  2 Nat								
Div To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (check only one)  1  Certifying Physician: To the best of my know 2  Medical Examiner: On the basis of examination and manner stated.	/ledge, death	h occurred at the tin exestigation, in my o	ne, date and place, ppinion, death occu	and due to the rred at the time,	cause(s) and mann date and place, ar	ner as stated. nd due to the cause(s)		
70 th within 70 th comp	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date signed (			
		Medical book	200	RES	-000		July 21	5,2008		
(3) M3			0,0101		Epral 600	North Wo	olfe St, Balt	imore, MD, 21287		
S Regis	tate	31. Date filed (Month, Day, Year)  32. Registrar's Signatu  1111 2 8 2008		hand!						

Division or Vital Records, P.O. Box 68760. ed by the a this e Hospital or Attendi 24 hours after death. e Funeral Director: A letely filled in by the fi To the Hospital within 24 hours a To the Funeral L

Certificate of Death 008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2223 Bernice E. Simms July 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 23 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M 2₩F Maryland 220-56-8347 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Hygiene. yther than "natural", or Items 23a or 28a-f show ent. the Medical Examiner must be notifled at MarylandPrince George's Lanham 1 ☐Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3022 Brightseat Rd. Apt 202 20706 USA death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite may Injury or other traumatic event, the Medical Examine once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Domestic Private Family 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Adams Georgianna Giles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mazie Contee(Daughter) 12501 Morano Dr. Brandywine, Md. 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOV Moses Cemetery 7-22-08 Drury, Md. Winname La Races of Racing ons Mortuary, P.A. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Co Cardio Vascular Physician /Medical Dilated Cardio myopath Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Congestive burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an rmeo? 2 ☑ No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 2 1 Inpatient 2 ■ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and mapper stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death the Paul (Type, Print) Rd. Cheverly, Md. 6128 AKPan Landove Margaret 31. Date filed (Month, Day, Year) 2 5 2008 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar 31. Date filed (Month, Day,

Year!

Highway Sute 410 Woldorf, MD 20601

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 850 M Charles Scheffenacker /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Nicomico REGIONAL Medical CENTER SOCISBUM leninsula If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months 215-28-5163 1 X M 2 □ F Hours Director 81 11/20/1926 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examinat must be notified at Director 1 ¥Yes 2 ☐ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or it 1116 Granby's Run 21804 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 1 XYes 2 No If Yes, Give Year or Dates: Navy 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Sollege (1-4or 5+) developer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Preston Scheffenacker Louise (unknown) ဥ 19a. Informant's Name/Relationship (Type. Print)

Jerry Wilkins/step-son-in-law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30565 Fox Chase Dr., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 7/26/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Park Signature of Funeral Service License HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or conditi-resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery for 3 Ectopic pregnancy Day Year 4 Pregnant Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, pe 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1☐ Yes 2☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٩ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Manth, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

8

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Via

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year PAULINE 56 P M I. SHELTON 20 20 JULY 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Apr. 10, 1924 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 □ M 2√2 F 212-54-0889 84 Director Maryland Usual Residence of Decedent 10a State show 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director MD Montgomery Gaithersburg 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16411 Riffleford Road 20878 U.S.A. Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 INO Specify: à Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Domestic Department of Health and Mental Hygis Important: If item 27 is marked other t Home 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Be UKN Dorsey ပ Sarah Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie Shelton (Daughter) 16411 Riffleford Rd, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brooke Grove Cem | 7/28/08 4 Donation 5 ☐ Other (Specify) Laytonsville, MD 21. Signature of Funeral Service Live Aname and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician INTESTINAL disease or condition resulting in death) OBSTRUCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 1 Tyes 2 No. 9 Unknown ģ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ HYPERICALEMIA Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should been METABOLIC ACLOUSIS 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? Yes 2 2 No certificate 1 □Yes 2 🗷 No 1 ☐ Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No Certification: To this 1 Inpatient 2 I ER/Outpatient 3 I DOA funeral 28a. Date of Injury (Month, Day, Year) Hospital or Attending P 24 hours after death. Funeral Director: After t 27. Manner of Death After 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D0062562 Muchan suble TULY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL HUBBLY MADHAVI 9901 ROCKVILLE CENTUR BRIVE MARYLAND 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 28 Registrar 2008

		-	For State Registrar	State of Mary		Certificate of			Reg. No. 20	08 25714		
Pr.	Physicia	an	1. Decedent's Name (First, Middle, Last	SIMON				2. Date of Dea Month		Year 1340 M		
	/Medic	_	4a. Facility Name (If not institution, give	street and number)	<u> </u>	4b. City, Town, o	r Location of Death	+ .	4c. County of	of Death		
		H	Anne Arundel Medi  5. Social Security Number 6. Se		Arundel  9. Birthplace (State or Foreign							
	Funeral Director		167-22-0660	2 F 7. Age (1	In yrs. last bir 80	thday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3/17/19	) 28 1	Pennsylvania		
	yland now at		Usual Residence of Decedent  10a. State  10b. County		0c. City, Town					10d. Inside City Limits		
	ne Mar 8a-fsl otified	ctor		rundel		Lothian				1 ☐ Yes 2 No		
	with the la or 2 to be no	Funeral Director	10g. Citize 10f. Zip Code 20711							hat Country?		
	death	nera	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H		pecify Yes or No-		- American Indian, , White, etc.		
020	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 🔼 Married 3 □ Widowed 4 □ Divorced		1951 <del>-</del> 1955	1 ☐ Yes 2√√No		or mount, own,		white		
2	n 72 hc "natu edical	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of world)	king	16b. Kind of Bus	siness/Industry		
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2	be filectal Hyg d othe	Be C	17. Father's Name (First, Middle, Last)					,	Maiden Surname	9)		
7	hould den marke marke	은	Walter Simoni  19a. Informant's Name/Relationship (7)	Tyne Print)	19h	. Mailing Address (Street		Burchett		State, Zin Code)		
2	alth an 27 Is I		Myrtle Simoni	Spouse	1.	3 Sarah Anne						
ο Σ	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		20a. Method of Disposition  1 Burial 2 XCremation 3	Removal from State	20b. Place of cemete	f Disposition (Name of ry, crematory or other pla	i	Date	20c. Location - (	City or Town, State		
Daltillor	it. Pag rtment rtant: njury (	١,	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	1)	Atlan	tic Crematon 22. Name and Addre				rnie, MD		
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ľ			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the	e death. Do	not enter the mode of dyi	ing, such as cardiad	or respiratory ar	rrest,	Approximate Interval Between		
	Physician	4.1	Immediate Cause (Final disease or condition resulting in death)		Onset and Death							
C	/Medical Examiner			Due to (or as a d	consequence	of): 🌙						
	P #	ner	Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury									
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	consequence	of):						
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ecords,	w requires that been signed by should be deta							1 🗆 '	Yes 2□No	3 Probably 4 Unknown		
r	The law ate has b page 2 sk	Completed					<u>.</u>	24a. Was auto perfo 1 Yes	psy ormed?	Nere autopsy findings available prior to completion of cause of death? □Yes 2□ No		
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0	ding Phys h. After this funeral dir	n: To	27. Manner of Death	28a. Date of Injury	28b.	dipatient b_ box	Firme of 28c. Injury at 28d. Describe how injury at					
VISION	erdin earh. or: Aft the fun	atio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be									
Š	or Attendent effer death birector:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc.	y - At home, fa (Specify)	arm, street, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rural Route Number,		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical C			examination a	e, death occurred at the nd/or investigation, in my						
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,	X	X	30. Name and address of person who Stord Blub, My	completed cause of dea	ath (Item 23a)	(Type, Print)	Zunapoli	, MD				
	St Regist	ate rar	30. Name and address of person who Sheld, Man 1995 and 19	2008 32. Registrar	's Signature	pole						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] [ ] 8 25715 3. Time of Death Year 800 6:00 of Death

		Registrar  1. Decedent's Nar	no /First Middle	( act)		Cer	tificate of	Deall	1	2. Date of De	Reg. No	).	3. Time of D	Doath
Physic	ian	_								Month	Da		r	p <sup>M</sup>
/Medi		Thomas	Clemens	Shapiro give street and numbe	ar)		4b. City, Town, o	or Location	n of Death	July	21	, 2008 . County of De	6:00	Р
Exami	ner			e Care & Reh				ersbur				Montgon		
Funeral		5. Social Security			Age (In yrs. las		If Under 1 Year	If Unde	er 24 Hrs.	8. Date of Bi	rth	9. E	Birthplace (State or	Foreign
Director		062-32-6	210	1☑M 2□F	69	Yrs.	Months Days	Hours	Hours Min. (Month, Day, May 10,				Country) lew York	ŭ
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72 hours after death with the Maryland nature!', or items 23a or 28e-f show alcel Examirer must be notified at	cto	Maryland	Montgo	mery	Di	ickers	n				_		1 🗆 Yes	2 <u>k</u> No
with the Maryland a or 28e-f show be notified at	Director	10e. Street and N	umber				10f. Zip Code				10g. Cit	tizen of What	Country?	
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items ref	Funeral	11. Marital Status		12. Was Deceder Armed Force		13. \	Vas Decedent of I Yes, specify Cub	Hispanic C an, Mexic	origin? (Spean, Puerto	ecify Yes or No Rican, etc.)	D-	14. Race - Ar Black, W	merican Indian, hite, etc.	
rsantero r, oriten xordrer			rried 2 Marrie	If Yes, Give	_	1	☐ Yes 2₺ No					Specify:		
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tygi her t.	ŏ	17. Father's Name	(First, Middle, La			СОпре	ter Engrie	· · · · · · · · · · · · · · · · · · ·	her's Name	First, Middle		Government Sub-Contracting Maiden Sumame)		
of Health and Mental Filem 27 is marked of	To Be	Harry	L. Shap	iro						Sandler	,			
mari mati	Ĕ		Name/Relationship			19b. Mailin	a Address (Street			ural Route Number, City or Town, State, Zip Code)				
Ith ar		Thomas C	. Shapiro.	Jr. / Son										
item 27 i		Thomas C. Shapiro, Jr. / Son 11101 Watkins Road; Germantown, MD 20876  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)								Oc. Location - City or Town, State				
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Department of important: if i any injury or once.			uneral Service Lie		<u>гг. ы</u> 1	22	Name and Addre	ess of Fac	ility			ntwood,	МП	
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		23a. Part1. Enter	the xs ase, or co	omplications that caus	ed the death.	Do not ente	er the mode of dyi	ng, such a	as cardiac o	or respiratory a	rrest,		Approximate Interval Betw	een
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death. tor: After to the funera	cation:	27. Manner of Dea 1 ☑ Natural	5 Pending	28a. Date of In (Month, D	Day Year)	3b. Time of Injury	28c. Inju. Wo			28d. Describe	now injui	ry occurred		
or:	cat	2 ☐ Accident 3 ☐ Suicide	investigat				M 1	Yes 2[	7140					

To the Hospitei or Atterwithin 24 hours after designate of the Funerei Directo completely filled in by the Certifi Medical

er (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

D41162

(Check only one) 29b. Signature and title of certifier

1 Medicel Exeminer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

July 22, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinu Ganti, M.D. 19529 Doctor Drive, Germantown, MD 20874

State Registrar

29a. Certifier

31. Date filed (Month, Day, Year) 2 5 2008



			State of Maryland /.Department of Health and Message State  1 - State Registrar AMEND#29 does 7-31-08, BMW, Mode Certificate of Death	ental Hygier	211118	25716						
	Physici /Medio Examin	al		2. Date of Death Month	Day 9 Year 2003 4c. County of Death	3. Time of Death  3. Time of Death						
	Funeral Director		Potomac Valley NSq. Home Rockville	8. Date of Birth (Month, Day, Yea 11-7-1922	ar)	Nend place (State or Foreign intry) oslavia						
	e Maryland Sa-f show	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MARYLINO MONTCOMERY Rockville			10d. Inside City Limits 1 ☆ Yes 2 ☐ No						
92	hours after death with the Maryland tural', or Itema 23a or 28a-f show al Exerction must be recitled at	Funerai	106. Street and Number  1235 Potomac Valley Road  11. Marital Status  1 □ Never Married 2 ☒ Married  1 □ Never Married 2 ☒ Married  1 □ Wideword 4 □ Diversed  1 □ Ves 2 ☒ No  1 □ Yes 2 ☒ No	Un:	ited Stat  14. Race - Amer Black, White	es ican Indian, , etc.						
21215-0036	I within 72 hours liene. r then *natural',	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Mechanical Engineer	g	Specify: Whi Kind of Business/li ransporta	ndustry						
Maryland 2	ould be filed Mental Hyg arked othe atic event,	To Be Co	17. Father's Name (First, Middle, Last)  Unknown  Unknown  Unknown	(First, Middle, Maid	len Sumame)							
	1 an Heal Heal ther		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural  17ina Sondermayer-Spouse  1235 Potomac Valley Roa  20a. Method of Disposition (Name of Day	ad, Rockv		20850						
Baltimore,	permit. Pages Depertment of I Important: If it any injury or o		1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licensee  Parklawn Cemetery July 2  22. Name and Address of Facility Simp	Ro 29, 2008 ole Tribut	ockville,	MD						
	Physician		Pike, Rockville, MD,  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	20852		Approximate Interval Between Onset and Death						
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P.O. Box 68	death certific e attending p ed for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   5   Other		23d. Date of dein	very Day Year						
Ś	sigr sigr	To Be Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?						
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Division	F 8 F C	Certification;	4 ☐ Homicide building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or within 24 hours af To the Funeral D completely filled in	Medicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, as € Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certifier  29c. License number	d at the time, date a	e(s) and manner as and place, and due Date signed (Month	to the cause(s)						
)	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1y 10,	2008 2008 October 1911						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Barbara Laverta Saucier /Medical 4a. Facility Name (If not institution, give street and number) 4c County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Feb. 8, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Louisiana 1 □ M 2 🛛 F 72 433-52-1821 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmet must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Frederick Maryland Smithsburg 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13539 John Cline Road 21783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton James Goodwin Laverta Kennedy မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Saucier / husband 13539 John Cline Road, Smithsburg, MD 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ Other (Specify) Smithsburg Cemetery Aug. 2, 2008 Smithsburg, Maryland 21. Signature of Fun 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part 1/ Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEP HAZITI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ES PIRATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sorieuquenee of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed 212932 signed by the aftending physician and I be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, METMBOLIC Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) I□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ HTPENTENSION 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed this certificate has been at director, page 2 should DISENSE 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? res 24 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

in 24 hours area the Funeral Director: Af within 2 To the

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 1 1

(1) NAC

DHMH 17 Rev 1/2001

and manner stated.

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32. Registrar's Signature

132420

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

10062006

E. ANTIETM

29d. Date signed (Month, Day, Year)

ATTHOUSTONIN, MY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Paul H. Seiser August 4, P M 2008 2:42 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 3 Ali Drive Middletown Frederick Date of Birth (Month, Day, Year)
April 3, 1945 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Days Hours 1 X M 2 □ F Months 153-34-8167 63 New Jersev Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Middletown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Ali Drive 21769 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Maryes 2 ☐ I If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Vietnam Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Corporate Paper Products Regional Sales Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert John Seiser Florence Jensen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Seiser / Wife 3 Ali Drive, Middletown, Maryland 21769 20b. Place of Disposition (Name of cemetery, crematory or other place Christ Reformed United 20a. Method of Disposition Date 20c. Location - City or Town, State August 8 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Middletown, Maryland Church of Christ Cemetery 21. Signature of Funeral Servi 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Due to (or as a consequence of): 96 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 1 ☐ Yes 24 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2PhNo 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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r than "natural", or items 23a or 28a-f sho the Medical Evaminer must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Modical Evantmen

Baltimore, Maryland 21215-0036

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law requires that the death certificate be executed

Box 68760;

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Hospital or Attending Physician:

To the Hospital within 24 hours a To the Funeral C

Examiner ending physician and use as the burial-trans Physician/Medical signed by the a Completed by peen page 2 s certificate director, 2 this ours after death.

neral Director: After this filled in by the funeral d Certification:

IF FEMALE:

29b. Signature and title of certifier

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1014625

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one)

1007 Natural

2 Accident

4 Homicide

3 Suicide

29c. License number

29d. Date signed (Month, Day, Year)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Gregory Rausch, M.D. \$\square\$501 West Sevents Street, Frederick, Maryland 21701-4507

State Registrar

Medical

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Constance Josephine Troxel July 25, 2008 9:11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 □ M 2 🛣 F Director 208-18-0967 82 1926 June 6, Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Illimportant: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If a Marical Examinar misst be notified once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9120 Gue Road 20872 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White <u>Ş</u> 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Joseph P. Kaleita Mary Ann Panak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9120 Gue Road, Damascus, Maryland Dennis Troxel, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) Metropolitan Crematory 7/27/2008 | Alexandria, Virginia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limmediate Cause (Final disease or con Won resulting in death) 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Intracrania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed Cerebrorasalar attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐Yes 2 ☐ No 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

12 State

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ORIGINAL.

Akhondi Hossein, MD, 8600 Old Georgetown Road, Bethesda, Maryland

32. Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

0062167

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Honth 2 3, 2008 **Physician** Shirley Tilman Lee /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisbury Wicomico Rehaban Ursing If Under 1 Year | If Under 24 Hgs. 8. Date of Birth (Month, Day, Year) 10/19/1932 9. Birthplace (State or Foreign Country) Maryland 6. Sex Social Security Number **Funeral** Days Months 1 M 2 XF 75 220-28-0018 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 200 Civic Ave. 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Examiner and. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2**7**] No 1 ☐ Yes 2 ☐XNo Specify. þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper accounting/payroll Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Cornelius Stockton Mattie Hastings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan T. Miller/daughter 6244 Firetower Rd., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Paule St. Episcopal 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 7/25/08 Vienna, MD nature of Funeral Service Licensee 22 Name and Address of Facility al Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Mompson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a nonsequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe this certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ NO 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 | Inpatient eral Director: After thi filled in by the funeral 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ Accident 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie

State Registrar

Robins, N.D. William H. 31. Date filed (Month, Day, Year) JUL 2,8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ivic Ave. Salisbury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death 4:20 P M 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George's Community Hospital Prince George's Cjeverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 29,1933 9. Birthplace (State or Foreign Months Days Hours Min. North Carolina 1 □ M 20€ F 578-48-4997 75 May Usual Residence of Decedent 10a. State 10c. City. Town or Location 10h. County 10d Inside City Limits 1⊠Yes 2 No MD Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6325 Carrington Court 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Specify: Black 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alston Copelin Mahalia Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Townes - Husband 6325 Carrington Ct., Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Chapel Cemetery 07/30/08 Hollister, NC 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Sanders & Sons Mortuary Service 7908 Kincannon Place, Lorton, 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fatal avvi disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner burial-tran physician Physician/Medical the for use as attending ate has been signed by the page 2 should be detached þ Completed certificate 24 hours after death.

Funeral Director: After this certific: etely filled in by the funeral director, I Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 No
G I Inknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 2 No 1∐ Yes 27. Manner of Death Natural 2 Accident

5 Pending investigation 6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Drive Cheverly NuD 20785

26. Place of Death (Check only one)

29a. Certifier (Check only one)

Medical

3 Suicide

4 Homicide

Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2🗖 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signatur

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

28a

MATIN 31. Date filed (Month, Day, Year) State 28

JUL

3001 Registrar's Signature

Hospital

Registrar

To the within 2

			for State Registrar	State o	of Marylan		artment of F		ınd Men		giene Reg. No.20	80	25722
	Physici /Medio		1. Decedent's Name (First, Middle Regina Ann	<sub>e, Last)</sub> Tankisley					N	Date of Dea Month	Day	Year	3. Time of Death 4:33 PM
	Examin Funeral Director	ner	4a. Facility Name (If not institution  6a) Timbre Wask  5. Social Security Number  578-78-4993  Usual Residence of Decedent	-			4b. City, Town, o		9 4 Hrs.   8, D	Date of Birth Month, Day	, Year)	e A 9. Birthp Cour	runde/ place (State or Foreign arry)
	Sa-f show	ctor	10a. State 10b. County	rince Geo		y, Town or Lo	cation Iyattsvil	le.			10d. Inside City Lim 1 □Yes 2√⊡1		
1	23a or 2	al Directo	1404 Quebec \$	Street			10f. Zip Code	0783		1	USA	What Cour	itry?
J.50	ii", or items	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marr  3 □ Widowed 4 □ Divorced	Armed Fo	2 <b>∑</b> No ive		Vas Decedent of H iYes, specify Cuba □Yes 2 ☑ No	lispanic Origi an, Mexican, Specify:	in? (Specify` Puerto Ricar	Yes or No- n, etc.)	Blac	ce - Americ ck, White, o	etc.
aryiand 21213-0036	ital Hygiene.  tal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education		(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired	durina most d	of working		16b. Kind of Br	usiness/Ind	dustry
מייים לייים	al Hygie	Be Co	17. Father's Name (First, Middle,	Last)	L	Нош	emaker_	18. Mother	's Name (Firs	st, Middle, I	Own Maiden Surnan	Home	
ylai Ylai	d Ment narked natic e	일	John Dmohoski			T			la Jar			_	
, <b>Ka</b>	alth an 127 is r		19a. Informant's Name/Relationsl Patricia A. Mye		ter		g Address <i>(Street</i> O Samant						
Dalumore	Popartiment of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, ITeM once.		20a. Method of Disposition  1		State C	emetery, cřem	sition (Name of atory or other place eaven Ce	1	July 7 200	28,	20c. Location -		wn, State
Dall	Depart Import any inj		21. Signature of Funeral Service	Stol	Pe	22 F 5	Name and Addre rancis J 00 Unive	ss of Facility • Coll rsity	ins Fu Blvd,	nera	l Home Silver	Inc. Sprin	g, MD 2090:
re be executed in	nysician /Medical xaminer the privap-transit	edical Examiner	23a. Part1. Enter the disease, or shock, or heart fallure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. Due to c.	(or as a consequ (or as a consequ (or as a consequ	uence of):	free mode of dylin	g, such as c	ardiac or res	piratory arr	est,		Approximate Interval Between Onset and Death
Physician: The law requires that the death certifical	ned by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 Live	tcome of pregna birth 2□ Fetal nant at time of d lown	death 3 🗆	Ectopic pregnancy Other (specify)	4				te of delive	ery Day Year
guires that	been signed b	ğ	Part II. Other significant conditio	ns contributing to de	eath but not resu	llting in the un	derlying cause give	en in Part I.			_	_	e cause of death?
in: The law is	certificate has be ector, page 2 sho	e Completed	25. Was case referred to medical						1		ned?	Were autoportion to condeath?	osy findings available inpletion of cause of
hysicia	this certific al director,	To B	examiner?	Hospital:	I <del>npati</del> ent 2 □ I	ER/Outpatient	3 □ DOA Othe	ar:	of Death (Che		<i>e)</i> ence 6 □Oth	er (Specif)	
- 0	ا فور ا	Certification:	27. Manner of Death  1 Autural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation ot be	of Injury th, Day, Year) of Injury - At ho	28b. Time of Injury		yat ?? Yes 2∐No	0		w Injury occurr		I Pout Musel
spital or /			4 ☐ Homicide determi	g Physician: To the	ng, etc. (Specify	")		no data and	C	ity or Towr	n, State)		I Route Number,
the Hos	nin 24 h the Fur npletely	Medical	(Check only 2 Medical E	examiner: On the b	asis of examinat ner stated.	ion and/or inv	estigation, in my o	pinion, death	occurred at	the time, d	ate and place,	and due to	the cause(s)
To	Mil will	2	29b. Signature and title of certifier	niden			29c. License		+>		9d. Date signed		
	, ,		30. Name and address of person v	n 305	e of death (Item	23a) (Type, P	rint) Sut	E 30	25 (	Olen	Burnia	M	1) 2016)
	Stat Registra		31. Date filed (Month, Day, Year)	2008	egistrar's Signat	ure A	all s						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2008 enee Jul /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Tilghman Island Talbot 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 532-68-3909 Months Days Hours Min 1□ M 2 F Director Nashington Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at albot 1 Nes 2 No Funeral Director McDaniel hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21647 ISland S A - American Indian, Man Race 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 Widowed 4 Divorced Black "natural", marked other than "natur umatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked 1 any InJury or other traumatic ew once. ockridge 2 HNO rew 00 Se 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 97728-Tolghman Tsland Rd.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date McDaniel MD 21641 ouise 20a. Method of Disposition 20c. Location - City or Town, State 1 PBurial 2 □ Cremation 3 □ Removal from State laiborne Cemetery 117/08 McDaniel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of acility HOME, P.A. HENRY FUNERAL HOME 510 Washington St. C MD121613 ambridge 23a. Palet. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ronic /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day 5 Other (specify) ed by the a 9 Unknown s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Yes or Attending Physician: Medical Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one examiner2 Hospital: 1 ☐ Inpatient 1 🗌 Yes Other: 2 ER/Outpatient 3 DOA 4 \Bursing Home 5 Residence 6 ☐Other (Specify) 28a. Date of Injury Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 12 Natural (Month, Day Year) 5 ☐ Pending investigation 1 🗌 Yes 2 □ No 2 T Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

P.0.

or Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Туре, Print)

00061822

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 9ay JATT 2008 0258 **Physician** Felicia D. Wood /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis 238 Croll Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1 □ M 2 🕶 F Yrs. 1952 55 Sept 215-64-3848 Director Usual Residence of Decedent with the Meryland 10d. Inside City Limits 10c. City, Town or Location 10b. County show if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be multified at Yes 2 No Maryland Anne Arundel Annapolis Director 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 USA 238 Croll Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{X} \) No 11 Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Annapolis Bus Co. 12th 0 Support Staff 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles J. Wood Martha Wallace ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh De ortment of Health and Important: if item 27 is rr any injury or other traum 16014 Pin Oak Ridge St. Houston, Texas Seth Harris(Son) 20c. Location - City or Town, State 20a. Method of Disposition Date 205 Recent Disposition (Name of Cemetery, Crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-23-08 Annapolis Annapolis Neck 4 Donation 5 Dother (Specify) Windlame Reverse of Sacilicians Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 1 1, 12en 1100983 Approximate Interval Between Onset and Death 23a. Part 1. En if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ending physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No Ö 9 Unknown 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural .tal or At.
Jurs after dea.
I Director: A.
in by the 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

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State

30. Name and address of person who c

31. Date filed (Month, Day,

Me

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medical Plwy #310 Amapolis, MD

ted cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3:45 PM SARAH R. WHITICO WINFIELD JULY 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SMITH'S CARE FOR THE ELDERLY HARFORD **EDGEWOOD** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 □ M 2 🗙 F 94 Yrs. 165-12-0370 DEC 19, 1913 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No MARYLAND HARFORD **EDGEWOOD** 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 1205 HANSON ROAD 21040 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC PRIVATE HOMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM WHITICO FLORENCE (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACE PROPHET / NIECE 2504 N. MONROE STREET, WILMINGTON, DELAWARE 19802 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State R.A. FERRIS & CO. 7/29/08 4 ☐ Donation 5 ☐ Other (Specify) WEST CHESTER. PA 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 Approximate 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EREBEAL 20 DAUS Due to (or as a consequence of): XLZHETHER'S OVER 34FM if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ral", or Items 23a or Examiner must be r

natural",

is marked

permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once.

Medical

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death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

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Records,

or Vital

Division

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Funeral

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after death the

within 24 hours a To the Funeral I Hospital

sician and burial-tran physician s the burial jo signed by the a d be detached f page 2

Examine Physician/Medical þ Completed Be Certification: To 27. Manner of Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

14581516D L-1V1X

25. Was case referred to medical examiner?

6 ☐ Could not be

5 Pending investigation

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

28d. Describe how injury occurred

1∐ Yes

26. Place of Death Check onl one

29a. Certifier

1 ☐ Yes

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. DOO 16389

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERFECTO C. VALARAD, M. D. 1716 HARFORD EN Suite 105 PALLSTON MO 4047 31. Date filed (Month, Day, Year)

State Registrar

29b. Signature and the of certifler

2 No

2008 JUL 2 9



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2008 **Physician** William Simpson Wise 21, July 12:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner College View Nursing Center Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 8, 1923 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months 12 M 2□ F 84 Washington, D.C. Director 577-12-9570 Usual Residence of Decedent death with the Maryland 10a State 10h County 10c City Town or Location 10d. Inside City Limits Item 27 is merked other than "natural", or items 23a or 28a-f show other traumatic event, the Medicel Examiner must be notified at 1 X Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 700 Toll House Avenue 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is merked other than "natural", or itel 1 □ Never Married 2 X Married Saltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Estate Appraisor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Montgomery Wise Hilda Simpson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Wise / Daughter Fairview Ave., Frederick, MD 21701 Date 23 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July" Department of Important: If It eny Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Frederick, Maryland 21. Signature of Eureral Service Lice Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Pa 41. Enter the disea shock, or heart failure Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. immediate Cause (Final **Physician** disease or condition resulting in death) /Medical MONTHS Examiner Usles M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 9☐ Unknown Day 5 ☐ Other (specify) been signed by the should be detached I Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Artery Dilease. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica uneral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20061223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 196 TJOLIVE, FREDERICE, MD -21702 55 CARVY TO 1 32. Registrar's Signature PLAYEEM State

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Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

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		1 - For Amend Item 3	State of Marylan	<b>%3/297698</b> <i>Certifica</i>	nt of Health and I hite of Death	vientai Hyt	$_{\text{Reg. No.}}^{\text{giene}} 2008$	25727
		Decedent's Name (First, Middle, Last)	) ~	. 1	1	2. Date of Dea	ath	3. Time of Death
Physicia /Modia		Ollie	Diane	Ward	1	Month	Day Year	0152 M
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. Cit	y, Town, or Location of Death		4c. County of Dea	th
		PENIASULA REGIONA	L Medical	Conse	salisbui	inf	Hico	
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	Months	er 1 Year   If Under 24 Hrs. s Days Hours Min.	8. Date of Birt (Month, Da	h <b>l (V 1 4/48</b> 9. Bir y, Year) / C	thplace (State or Foreign
Director		Usual Residence of Decedent		9 Yrs.		10-14	08 1	(D)
/land		10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits
Mary a-fsh	햕	MD. Worce	ster C	snow Hil	(			1 ZAYes 2 □ No
er death with the Marylan tems 23a or 28a-f show	Director	10e. Street and Number	1 .	10f. Z	Zip Code		10g. Citizen of What C	ountry?
tth wi	ral	501 Maple St. A	tot, 204		21863		USA	
er death w items 23a	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (S pecify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whit	
ours after	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🗷 Divorced	1 ∐Yes 2 🔼 No If Yes, Give Year or Dates:	1 □Yes	2 ☐ No Specify:		Specify: R	lack
be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene dother than "natural", or items 23a or 28a-f show event, I'm in dical Eva i in the matter of difficults.	ed	15. Decedent's Edu	cation	16a. Decedent's Us	sual Occupation		16b. Kind of Business	/Industry
hin 72 9. <b>an</b> " <b>n</b> a	ple	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give kind of w life. DO NOT	vork done during most of wor use retired)	king	2 .	-
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be file tal H d oth event	Be	17. Father's Name (First, Middle, Last)	. (		18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
2 should and Men is marke aumatic	은	Howard	Mard	-	011	16 2	tewart	
d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (T)	1- 1+	19b. Mailing Addre	ss (Street and Number or Ru	111 4	er, City or Town, State,	Zip Code)
1 and Health tem 27 other tr		20a. Method of Disposition	in - daughter	Place of Disposition (N	ndiana (tye,	Date	20c. Location - City of	7 08401 Town, State
Pages nent of int: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crematory or	r other place)	1108	1	6 4 1
# 문문분		21. Signature of Funeral Service Licens			and Address of Facility	100	Lansoni 30639	Hampden Ave
Depa Impo any ir		+nthone &	Ward In	Antho	ny Word Fund	ral Hom		
		23a. Part 1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused the deat		7 10010		rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	A	scloroti	c Condiev	19204/0	v discare	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq	juence of):				
Lxammer	1	Sequentially list conditions,	b					
rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence or):				
be executed ician and burial-transit	Еха	that initiated events resulting in death) Last	c Due to (or as a conseq	juence of):				
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rtifica ng ph as th	/led	IF FEMALE:			-			
ath ce ttendi or use	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		pregnancy		23d. Date of de	
ne dea the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of € 9 ☐ Unknown	death 5 Other	(specify)		Month	Day Year
that the death certificated by the attending phetached for use as the	Ph	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
re law requires t has been signe ge 2 should be c	d by			, ,	,	1 🗆 ነ	/es 2□No 3□F	Probably 4 Tunknown
w req	lete					24a. Was	an 24h Were a	utopsy findings available
The la te has	Completed			<del></del>		autop	rmed2 prior to	completion of cause of
lan: ] rtifica tor, p	Be C	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes		s 2 No
nysic nis ce direc		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 ☐ I	Other:		dence 6 ☐Other (Sp	ecify)
ng P	ë.:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe I	now injury occurred	
teath. tor: / the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	20 20	М	1 ☐ Yes 2 ☐ No			
or At after d Direc in by	Certification: To	4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, facto fy)	ory, office	28f. Location (8 City or Tov	Street and Number or F vn, State)	Rural Route Number,
spital		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge, death occurre	ed at the time, date and place	e, and due to the	cause(s) and manner	as stated.
To the Hospital or Attending Physiclan: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Exam one)	iner: On the basis of examina and manner stated.	ation and/or investigati	on, in my opinion, death occu	irred at the time,	date and place, and du	e to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	./ ./	2	29c. License number		29d. Date signed (Mor	
}		12 3	Mul		D54807		7/24/20	28
•		30. Name and address of person who co						
		31. Date filed (Month Day, Year)	100 E. Carroll :	St. SHisbu	ry md. 21801			
Sta Registr			32. Registrar's Signa 2008	1. Anna	6,			

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

**Funeral** 

Director

Physician /Medical Examiner

attending physician and I for use as the bunal-transit signed by the atte

The law requires that the death certificate be executed this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

22, 9:37 A M 2008 4c. County of Death 449 Cloverdale Circle Severna Park Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 ₹ M 2 □ F Months Days Hours Міп 052-22-9778 80 Maryland Apr. 16,1928 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Anne Arundel Severna Park 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21146 449 Cloverdale Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Presstar Plant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Foichat John F. Wenger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Saw Grass Drive Martinez, GA 30907 Eric M. Wenger/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Glen Haven Memorial July 26, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD 4 Donation 5 Dother (Specify) 2008 Park Signature of Paneral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZOVES disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 1 Yes 2□ No 3□ DOA Other: ၉ 2 ER/Outpatient 4 ☐ Nursing Home 5 esidence 6 Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

filed (Month, Day, Year)
JUL 2 5

2008

31. Date

		-	1- State of Maryland / Department of Health and Mel Certificate of Death		2008 25729
	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day 23 Year 9 2:00 PM
	/Medic	al	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		1c. County of Death
į	Examin	er	21 Sheridan Road Arnold		Anne Arundel
i pari	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Year uly 17,	9. Birthplace (State or Foreign Country) Pennsylvania
5	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Maryl a-f sho fied a	tor	Maryland Anne Arundel Arnold		1 □Yes 2√T√No
	or 28¢	Director	10e. Street and Number 10f. Zip Code		Citizen of What Country?
	s 23a nust b	eral	21 Sheridan Road 21012  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specif		ited States  14. Race - American Indian,
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes XYNo If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	Black, White, etc.  Specify: White
Maryland 21215-0036	72 ho "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/Industry
121	within iene. the Me	dmo	Elementary/Secondary (0-12)  College (1-4or 5+)  Registered Nurse		Nurse
nd 2	be filed vital Hygie d other i	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	First, Middle, Maid	ien Surname)
ylaı	should be and Menta s marked umatic ev	10 E	Elwood H. Worman Marguerit		
Mar	d2sh thand 7ism traum		19a. Informant's Name/Relationship (Type. Print)  Charles R. Wheeler / Husband  21 Sheridan Road Arnol		y or Town, State, Zip Code) and 21012
	s 1 and f Health Item 27 other to	1/3	20a. Method of Disposition 20b. Place of Disposition (Name of Dispositio		Location - City or Town, State
E O	Page: nent o int: If I		4 Donation 5 Other (Specify)  Baltimore Crematory 7/25/2		ltimore, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility John 147 Duke of Gloucest	-	or Funeral Home, Inc. nnapolis, MD 21401
ļ.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. METASTATIC NONSMALL COLL LUNG resulting in death)	CHICIN	OMA
1	Examiner		Due to (or as a consequence of):		
	D #	iner	Seque hitally flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
_	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C		
68760,	ificate be executed g physician and as the burial-transit		d		
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.O. Box	requires that the death certi een signed by the attending nould be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
rds, P	w requires that the de been signed by the s should be detached i	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
I Record	The law ate has b page 2 sl	Completed		24a. Was an autopsy performed 1□ Yes	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:   Department   2D EB/Outpatient   2D DOA   Other:   Department   2D DOA   Other:   D DOA	\/	
or	g Physer this eral di	٦: <u>۲</u>	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	ne 5 Residence 8d. Describe how in	e 6 Other (Specify)  njury occurred
ion	Attending Ir death. ector: After by the funer	atio	2 Accident investigation M 1 Yes 2 No		
Division	al or Attens s after deatl al Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28	8f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in h	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
•	To the I within 2.	ME	29b. Signature and the of certifie 12b. Signature and the office  29d.	Date signed (Month, Day, Year)	
	150gr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HOLLY DISHELL MD ANNAPOLIS ON COLORY CENTER 900 BC.	strak Re	1 Sufe 300 Annagolis,
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 2 5 2008  37 Registrar's Signature		, and a second

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Francis Augustine Welch, Jr. July 23 2008 10:15 a 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min **№** М 2 🗆 F 022-16-0724 June 21. 1921 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐Yes 2- No Maryland Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 15101 Interlachen Drive, #708 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ¥Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 1943-46 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Administrative Law 17. Father's Name (First, Middle, Last) Judge 18. Mother's Name (First, Middle, Maiden Surname) Francis Augustine Welch, Sr. Kathleen Elizabeth Harrington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothea M. Welch/Wife 15101 Interlachen Drive, #708, Silver Spring, MD 209 $\phi$ 6 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 29 2008 Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSI S weeks. disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONALY ARTERY DIJPASPS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy death? 2 4 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Funeral

**Director** 

show

Director

Funeral

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Completed

Be

ir than "natural", or items 23a or 28a-f show the Wickell Experience cast be notified at

72 hours after

Pages 1

I Hygiene.

Department of Health and Mental Hygic Important: If item 27 Is marked other is any Injury or other traumatic event, It once.

Baltimore, Maryland 21215-0036

and burial-tran physician the attending pl signed I page 2 should

Physician/Medical

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Be Completed

Certification: To

Medical

29a, Certifier (Check only one)

requires that the death certificate be executed funeral director, After t or Attending 24 hours after deatl filled in by the Hospital

Division of Vital Records, P.O. Box 68760

within To the 1241

the

29b. Signature and title of certifier 000 J/ an D0050545 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Codswich O. 7513 New Hampshire Avenue Takama Park M. 31. Date filed (Month, Day, Year) 32 Registrar's Signature 25 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year Donald Williamson, Sr. Sterling 8:18 p M /Medical July 22 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Rockville 12705 Caldwell Street Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Yea March 16, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min. 1**X** M 2 □ F 578-46-7955 74 Director 1934 Washington, DC Usual Residence of Decedent 10a, State 10b. County show 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, I've Modical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12705 Caldwell Street 20853 USA Funeral death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2**%**No Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Government College (1-4or 5+) Elementary/Secondary (0-12) Printer Printing Office 12 nt of Health and Mental Hygir If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd Magruder Williamson Agnes Beard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald S. Williamson, II/ son 100 Sunset Avenue, Mt. Airy, Maryland 21771 injury or other 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If Itel
any injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State July 28 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 2008 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Myocardial Infarction immediate /Medical Due to (or as a consequence of): Examiner Arteriosclerosis Sequentially list conditions years Examiner Due to for as a conseque if any leading to include ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): burialphysician Box 68760 Physician/Medical the attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 □Yes 2 □ No the 9 Unknown þ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed Abdominal Aortic Aneurysm, Chronic Obstructive Pulmomary 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an nas page 2 Disorder autopsy performed? certificate **Division of Vital** 1 □Yes 2**x**xNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \overline{\text{Nesidence}} \) 6 \( \text{Other (Specify)} \) 1 ∐Yes 2 LayNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title Acertifie ٥ 29c. License number 29d. Date signed (Month, Day, Year) D02338 July 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard P. Delaney, MD 3929 Ferrara Drive, Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 25 2008

Registrar

			For State of Maryla  1 - State Registrar	and / Department of F Certificate of I		giene Reg. No. 2008	25732
	- · · ·		Decedent's Name (First, Middle, Last)	i / 11.	2. Date of Do	eath	3. Time of Death
	Physici /Medio		BERNICE Williams	WIKINSON	Augus	t 2 200 Year	
	Examin	er	4a. Facility Name (If not institution, give street and number)	CENTER PANA		4c. County of Dea	ARUNDE/
ı	Funeral Director		578-07-2278 1□M 2夂F	94 Yrs. If Under 1 Year Months Days	Hours Min. 8. Date of Bi (Month, D) 3/12/	ay, Year) Co	thplace (State of Foreign ountry) SC
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. 0	City, Town or Location			10d. Inside City Limits
	e Mar) 3a-f sh ulfied	ctor	MD Anne Arundel	Annapolis			1 □ Yes 2√∑No
	3a or 28	I Dire	10e. Street and Number 6207 River Crescent DR.	10f. Zip Code 21401		10g. Citizen of What Co USA	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exemitm 1: sat the neithed at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  1 □ Never Married 2 □ Married If Yes, Give Year or Dates:	U.S. 13. Was Decedent of H If Yes, specify Cubs 1 □ Yes 202No	ispanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.) Specify:		
Baltimore, Maryland 21215-0036	in 72 hou n "natural Nedical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation luring most of working )	16b. Kind of Business	/Industry
212	ed with ygiene ier tha	Com	Elementary/Secondary (0-12) College (1-4or 5+) 12	Homemaker	•	Own Hom	e
/land	uld be filk Mental H irked oth	To Be	John Butler Williams		18. Mother's Name (First, Middle Annie Sue Rich		
Mary	nd 2 sho alth and 1 27 is ma ir trauma	•	19a. Informant's Name/Relationship (Type. Print)  Dan Wilkinson Son	19b. Mailing Address (Street 2762 Cedar Dr	and Number or Rural Route Number. Riva, MD 211		Zip Code)
nore,	ages 1 a ent of He it; If item y or othe		T Dunar 2 Demailor 3 Dhemovarion State	Place of Disposition (Name of cemetery, crematory or other place)	i	20c. Location - City or	
Baltii	permit. P Departm Importar any injur		4 □ Donation 5 ☑ Other (Specify) Entombment H  21. Signature of Funeral Service Licensee		ss of Facility Hardesty I		
	_		23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each light.			T-15-7	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	ulure to	Thrave		Onset and Death
1	/Medical Examiner		resulting in death)  Due to (or ar conse	equence of):	à		
	B ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events c.	equence of).			
A	xecuter and I-transi	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	aguanca of):			
68760,	ificate be executed g physician and as the burial-transit	edical E	d.	equence on.			
	± 50 €	/Med	IF FEMALE: 23c. If yes, outcome of pred	unancy		004 D-46 4-	E
P.O. Box	The law requires that the death cer are has been signed by the attendin page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 No 9 ☐ Unknown	etal death 3 🗌 Ectopic pregnanc		23d. Date of de Month	Day Year
rds, F	w requires that the disbeen signed by the should be detached	ğ	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause give	en in Part I. 23e. Did	tobacco use contribute to	o the cause of death?
Division of Vital Records,	ilcian; The law re certificate has ber ector, page 2 sho	Completed	0				utopsy findings available completion of cause of
Vita	Ician; sertifica ector, p	Be	25. Was case referred to medical examiner?	Lau	1 L Yes 26. Place of Death (Check only		
of	Phys er this e	To :	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ 27. Manney of Death 28a. Date of Injury	ER/Outpatient 3 DOA Other	4 Nursing Home 5 Res	idence 6 Other (Spe	ecify)
io.	ending ath. rr: Afte ne fune	atior	DENatural 5 ☐ Pending (Month, Ďay, Year) 2 ☐ Accident investigation	Injury Worl	? Yes 2 □ No	now injury occurred	
Divis	al or Atters al safter de l'Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, street, factory, office city)	28f. Location City or To	(Street and Number or R wn, State)	ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examiner and manner stated.	nowledge, death occurred at the tin ination and/or investigation, in my o	ne, date and place, and due to the pinion, death occurred at the time	e cause(s) and manner a , date and place, and due	s stated. e to the cause(s)
	To the vithing to the complete of the complete	Me	29b. Signature and title of certifier	29c. Licenso	o number 0 51 897	29d. Date signed (Mont	th, Day, Year)
	12		30. Name and address of person who completed cause of death (It	rem 23a) (Type, Print)	deka Vi	luclu	- 19200
	Sta Registr		31. Date filed (Month, Pay, Year) 32. Registrar's Sig	nature	I W EIII	Va use	1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per diperatment of Health and Mental Hygiene 25733 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year 08:13 AM 2008 Wilson revore Howard 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown
If Under Year If Under 24 Hrs 1114 Outer Drive Washing ton
9. Birthplace (State) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, ace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min Mary land 217-29-5180 29 Director 08/21 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits Show 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Michael Examination of the natified at Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1114 Outer United State Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any in]ury or other fraumath. Elementary/Secondary (0-12) N/A College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth I. Wilson Ruby A. Keyes ഉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby A. Wilson/Mother 1114 Outer Drive, Hagerstown, MD 21742 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 8/5/2008 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 5 Mar 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cabse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asphyxia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b. Intractable Seizure Sequentially list conditions, if any, leading to himme liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) burialattending physician Physician/Medical the as IF FEMALE: for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) the 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate I □Yes 2 □ No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certification: 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Funeral Director; stely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Thomicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali, Meadow View Drive; Hagerstown, MD 21742 19236 Year) Registrar's Signature State 2008 2015 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OB Month **Physician** LEBOLA NLOCK 155 08 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimore Secours Hospit-If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-46-9512 Usual Residence of Decedent 1☑M 2□F Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Kres 2 No Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 IIN St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. slac ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be and Mental H +nard 19a. Informant's Name/Relationsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224 15ter permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau 20b. Place of Disposition (Name cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ligenses of Fad OU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ch as cardiac or respiratory arrest, Septicemis Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of): physician a Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a Id be detached f P.O. 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate Vital 1∐ Yes 2 □No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No P 1 ☐ Yes 1 🗔 Impatient 2 ER/Outpatient 3□ DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. M 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) 00/00/00 Lyrician 0060292 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bon Daltimore, MD 21223 Secours 000 W. Boltimere St 31. Date filed (Month, Day, Year)

AIIG 1 1 2008 2. Registrar's Signature State CANAL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Day Norval Elwood Beals 2008 3:19p August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Westminster Carroll Hospice Dove House Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | May 25 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F 91 204-03-4955 Yrs Director 1917 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified anonge. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 931 Kent Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 □Yes 2 □ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No 2 Specify. Specify: white 3 ₩ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) General Motors Elementary/Secondary (0-12) College (1-4or 5+) auditor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Velma Gnagev John Henry Beals 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15785 Old Frederick Rd., Woodbine, MD 21797 Carol Malinowski (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Memorial 8-12-08 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Haight Funeral Home & Chapel Page Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 120515 DOYS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐Yes 2 ☐ No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After th funerai 27. Manner of Death 28a. Date of Injury (Month, Day, Year, 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Director: A in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 60059943 11,2008

Registrar

State

Westminster

30

Stoner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

onn ( . Aselmo

31. Date filed (Month, Day, Year)

			Plea	se Type or P							-		_	e.		
			For State Registrar	State of	waryian	•	ırtmen <i>tificat</i> e				nental Hy	/giene Reg. No	000	Ω	257	136
	DI		Decedent's Name (First, Middle)	, Last)							2. Date of D				3. Time of	Death
	Physicia /Medic		Robert Lemuel								Aug.	7,		8OC	5:45	AM
1	Examin	er	4a. Facility Name (If not institution		· ·				Location				. County of			
	Funeral		Carroll Hospice 5. Social Security Number 242-20-6732		Age (In yrs. 84	last birthday) Yrs.	Westi If Under Months		If Under Hours		8. Date of Bi (Month, D	rth	arrol.		ce (State o	or Foreign
- T	Director		Usual Residence of Decedent	A	04	115.					Aug. 2	0, 1	923		NC	_
Maryland	-f show	tor	MD Carre	511		y, Town or Lo dersbui								10d	. Inside Ci 1 ☐ Yes	
dt dt	or 28a	Funeral Director	10e. Street and Number				10f. Zip						itizen of Wha	at Country	/?	
w He	s 23a	eral	6516 Ridenour	-		0 1101	2178					USA				
o atter de	or item	by Fun	11. Marital Status  1 □ Never Married 2 ☑ Marr  3 □ Widowed 4 □ Divorced	If <del>Ye</del> s, Give	es? □No t.π./T⁻	_   '	vas Deced fYes, sped I∐Yes 2	ify Cuba	ispanic Or n, Mexicai <i>Specify</i> :	n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:	White, etc		
	atural		15. Deceden	Year or Date 's Education	es: *****	16a. Deced	dent's Usua	i Occupa	ation		_	16b. H	Kind of Busin			
should be filed within 72 hours after death with the Manuland	Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ones.	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	kind of wor DO NOT us Cintel	e retired,	luring mos )	t of work	ing	U	S Gove	ernme	ent	
Dalij od	tal Hyg d othe event,	Bec	17. Father's Name (First, Middle,	,	0				18. Moth		e (First, Middle	e, Maidei	~			
y y	d Men marke matic	ပ္	Robert Lemuc	·	Sr.	405 14-115-		(0)			Jones					
nd 2 s	alth an 27 Is r trau		Mrs. Freida W.		001150)						al Route Num. [1dersb				oae)	
2 2 2	of Her f Item r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	•	20b. F	Place of Dispo	sition (Nam	ne of	- 1		Date		ocation - Ci		n, State	
Pad	tant:		4 Donation 5 Dother (S)	pecify)		ke Viev	_mem	. Pa:	rk :	8/11	./08	Syk	esvil	le, M	ſD	
n de	Irripo any Ir		21. Signature of Funeral Service	Licensee,	· MI-N	764   <sup>22</sup>	IAIGH	d Addres	NERAL	HON	E & CH	ĄPĘĻ	, P.A.	•		
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death								704	A	pproximat	
PI	hysician		Immediate Cause (Final disease or condition	only one cause of each	Cho	911	M	(	21/2	CIM	OW	7			nset and i	
	Medical xaminer		resulting in death)	ueto	as a consequ	uence of):			1.4						_2-10_23	
		ner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	b. Due to (or	as a consequ	uance of).										
sexecuted	ın and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c												
	physician s the burial	_	resulting in doubly such	Due to (or	as a consequ	uence ot):										
Tificate	as the	Medic	I	d												
ath cel	attendin for use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2 🗆 Feta	Ideath 3	Ectopic p		,				23d. Date of			Year
the de	by the a	Physician/Medical	1 □Yes 2 □ No 9 □ Unknown	4 L Pregna 9 □ Unknov	nt at time of d	leath 5	Other (sp	ecify)					World	, 5	ау	rea:
The law requires that the death certificate be	signed t	by	Part II. Other significant condition	ns contributing to deal	h but not resi	ulting in the ur	nderlying ca	ause give	en in Part I				use contribu			
w regu	s peen s	leted	- JATTER	1(7)			_				24a. Wa:				oly 4 🗆 1	
The la	icate has	Completed									auto	opsy ormed? 2 N	prio dea	or to comp ath? Yes 2	y findings pletion of c	ause of
Physician:	s certil directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ №	Hospital:	nationt 2 🗆	ER/Outpatien	+ 3 \( \dagger \)	Othe	DF:		h <i>(Check only</i> ome 5 ☐ Res		c D Other	(0%)	Asi	21,2
_ 0	o o o	H 4	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	28a. Date of		28b. Time of Injury		8c. Injury Work	/ at	ursing ric	28d. Describe		6 Other ary occurred		1)001	
Attending	death.	icati	2 Accident investig	pation I	Injune At he	ome, farm, stre	M not factor.		Yes 2□	No	006 1	·0·		0 4		
a o	s after al Dire ed in b	Certification:	4 ☐ Homicide determ	ined building	, etc. (Specif	y)	set, lactory,	onice			28f. Location City or To	wn, Stat	rie)	or Hurai F	Toute Ivuii	iber,
la Hospi	within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical (	29a. Certifier 1 Certifyin (Check only one) Medical	g Physician: to the be Examiner: On the bas and manne	is of examina	wledge, death	occurred vestigation,	at the tin in my or	ne, date a pinion, dea	nd place, ath occur	and due to th red at the time	e cause( e, date ar	s) and manr nd place, and	ner as sta d due to th	ted. ne cause(s	3)
To	To th	Ž	29b. Signature and title of certifie				290	. License	number			29d D	ate signed (	Month, Da	y, Year)	
	~		30. Name and address of person.	No completed cause	of death (Item	23a) (Type	Print)	اکرو	/ در ا			9/	1/4	000		
6	/		HUSLY Galdaf	mis 555	Sout	to Coul	tu -	Strace	it (	ESH	yoster	HI	02115	7		
	Stat Registra		31. Date filed (Month, Day, Year)	6 completed cause 32. Reg	istrar's Signa	ture	Jan Jan	Carrie .								
	5,011			7 7 7 7 7	A CHARLES		0									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 8 Amend Items 25,27,28a-f per men 1820,08698/08dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Sarah Doloris Birchfield 08 48 am /Medical 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAltiMORE If Under 1 Yea 8. Date of Birth Month, Day, Ye Aug. 13 9. Birthplace Country) (State or Foreign **Funeral** <sup>Year)</sup>922 Months Days 1 □ M 2 □ M 212-44-2384 85 MD Director Usual Residence of Decedent 10c. City, Town or Location Essex 10d. Inside City Limits Show 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Wedical Evaluation must be morthly of Baltimore MD 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21221 100 Franklin Avenue death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 X No 10 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify White ≥ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 8th is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Frank W. Birchfield Josephine Simspon Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 32 Buttonwood Place Swedesboro NJ 08085 Department of Health a Important: If Item 27 is any Injury or other trau David Powell /son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 【XCremation 3 Removal from State 7/28/08 Baltimore MD Bayview Crematory: 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of F Connelly Funeral Home of Essex 21221 23a. Part V. Enter the disease, or con shock, or heart failure. List only plications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. TON APPROVED BY MEDICAL EXAMINER Examine if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) be executed burial-transi and Due to (or as a consequence of): CERTIFICAT Box 68760. attending physician Physician/Medical requires that the death certificate the use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ₫ Day Year P.O. I 5 Other (specify) the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 230 Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 □Yes 2 No 2 🗆 No uneral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 X Yes 2 X Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of p 28a. Date of Injury 28d. Describe how injury occurred 1 Natural 2 Natural 2 Naccident 3 Suicide 5 ☐ Pending investigation death. 07/24/08 Unknown M 1 □Yes 2 XNo Probable fall reral Director: / 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1000 Franklin Ave. ospital or A determined 4 ☐ Homicide Apt. 1203, Essex, MD To the Hospital within 24 hours a To the Funeral I Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier

State Registrar

Coarles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar's Signature

DR. MITRA, BIPASHA

31. Date filed /Month

KES 0000

9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD. 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of Marylan	-	urtment of h tificate of			lental Hy	giene Reg. No	2008	25739
	Physici	an	1. Decedent's Name (First, Middle, Las	1)					2. Date of De Month	eath Day	Year	3. Time of Death
78/2	/Medic	al	Margaret Cox	atroat and averban		4b. City, Town, o	v.l. eestion	of Dooth	Aug 6,		8 County of Deatl	2:03 P M
	Examin	er	4a. Facility Name (If not institution, give 6906 GlennDale 1	· · · · · · · · · · · · · · · · · · ·		Glenn D		ODeam			rince G	
Who	Funeral		Social Security Number 6. S	7. Age (In yrs.	ast birthday)	If Under 1 Year Months Days		er 24 Hrs.	8. Date of Bir	rth	9. Birtl	nplace (State or Foreign untry)
	Director		234-/8-/930	□M 2⊠F 59_	Yrs.	Months Days	Hours	IVIII1.	12/27			t Virginia
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City Limits
:	Mary a-f she fied a	tor	MD. Prince Ge	orge's Gle	nn Dal	e						1 XYes 2 No
:	or 284	Sire	10e. Street and Number			10f. Zip Code				10g. Citiz	zen of What Co	untry?
;	ath w	lal	6906 Glenn Dale				20,76				ted Stat	
36	d within 72 hours after death with the Maryland sjene. Than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic C pan, Mexic Specif		ecify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
9	72 hou natura lical E	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Deced	dent's Usual Occur	pation	net of work	dina	16b. Kit	nd of Business/	
21215-0036	within / iene. than "r the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done OO NOT use retire		ost of work	ang			
	e filed w al Hygier other tl vent, th		17. Father's Name (First, Middle, Last)	<u>4+</u>	Regi	stered Nu		her's Nam	e (First, Middle	Nurs		
lanc	Ω <b>⊕ ΤΟ Θ</b>	To Be	James Wildesen						cMahon	, maidon	ourname,	
Maryland	s 1 and 2 should be f Health and Menta tem 27 Is marked other traumatic ev	-	19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailir	ig Address (Street	l			per, City o	r Town, State, 2	(ip Code)
Σ,	1 and 2 Health a em 27 Is other tra		Kenneth J. Cox /	·		Glenn Da						)769 –
ore	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition  1 ☐ Burial 2 X Cremation 3 ☐	Hemovai from State		sition (Name of natory or other pla			Date	20c. Lo	cation - City or	Town, State
Baltimore,	nt. Pa ntmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of F	The second secon		n Cremato  Name and Addre	-		/2008			. Virgin <b>i</b> a
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Proceedings Service Total					-	o D A			more Ave. e, MD 20781
100			23a. Part1. Enter the disease, or comp	olications that caused the deat							CCSVIII	Approximate Interval Between
F	hysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	Metastat	ic brea	ast cance	er					Onset and Death 2-5 years
	/Medical		resulting in death)	Due to (or as a conseq		- 1						2 J years
	Examiner		Sequentially list conditions,	b								
Jk	nsit	Examine	Sequentially list conditions, if any, leading to immediate First Location Cause (Disease or injury that initiated events	Due to (or as a conseq	uence or):							
77	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):							
68760,	icate be executed physician and the burial-transit	dical		.d								
		Med	IF FEMALE:						1.5%			
Вох	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	death 3	Ectopic pregnand Other (specify)	су			1	23d. Date of del Month	ivery Day Year
0	0 0	ysic	1 ☐ Yes 2 反 No 9 ☐ Unknown	9□Unknown	eatii 5	Joiner (specify) _						
ر. ح	requires that the een signed by th hould be detache	by Pt	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause gi	ven in Par	t I.	23e. Did	tobacco u	ise contribute to	the cause of death?
ord	w require been signature	ted t							1 🗆	Yes 2	XINo 3∏Pr	obably 4 □Unknown
8	aw as b	ompleted							24a. Was	psv	prior to	topsy findings available completion of cause of
	ate pag	ပ္ပ							perf 1□ Yes	ormed? 2⊠ No	death? 1 ☐ Yes	2 □ No
Vital		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2	ER/Outpatier	ot Ot	hor:		th (Check only			
0			27. Manner of Death	28a. Date of Injury	28b. Time o	IL SEL DOA	4 🗆 1	Nursing H	ome 5 🔀 Res 28d. Describe		6 □Other (Spe y occurred	cify)
ion	Attending r death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		rk? ]Yes 2[	□No				
	or Attencafter death Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office			28f. Location City or To	(Street an own, State	d Number or Ru	ural Route Number,
	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b		29a. Certifier 1 ☑ Certifying Ph	ysician: To the best of my kno	wledge deat	h occurred at the t	imo dato	and place	and due to the	2 031100(0)	and manner of	actated
	e Hos 24 hc e Fun letely	Medical	(Check only 2 Medical Exam	niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, d	leath occu	rred at the time	e, date and	d place, and due	e to the cause(s)
	To the i	Me	29b. Signature and title of certification	411	17	29c. Licen	se numbe	r		29d. Dat	te signed (Mont	h, Day, Year)
	_			11/2	1	D43	361				8/7/200	8
	12		30. Name and address of person who		, , ,,							
	1	ot o	Robert S. Siegel, 31. Date filed (Month, Day, Year)	M.D., 2150 Pe	enn. Av	zenue, NV	1, #3	-428	, Washi	ngton	DC 20	037
÷.	Sta Regist		AUG 1 1	32. Registrar's Signa	A	150000						

			1 - For State of Maryland / Department / Department / Department / Department / Department / Dep	artment of Health	and Mental	Hygiene Reg. No.	008	25740
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Theresa Justine Czyz		2. Date Mon		Year O8	Time of Death
	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number)  FYANK IN GUARC HOSTITAL  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1 M 2 DXF 76 Yrs.	4b. City, Town, or Location  Post and the If Under 1 Year If Under 1 Months Days Hours	r 24 Hrs.   8. Date	Bar	9. Birthplace Country Maryla	e (State or Foreign
	Director Manual Manual		Usual Residence of Decedent  10a. State	cation	171,	/ 1932		Inside City Limits
	the Mary 28a-f sh	Director	MD Baltimore Baltimore	10f. Zip Code		10a, Citizen	of What Country?	1 □ Yes 2 ☑ No
	sath with	Funeral D	9900 Walther Blvd # 310	21234		USA		
9600	should be filed within 72 hours after death with the Maryland nd Mental Hygiene.  marked other than "natural", or items 23a or 28a-f show imatic event, the fedical Eventracinal Denotified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Year or Dates:	Vas Decedent of Hispanic On Yes, specify Cuban, Mexica  ☐ Yes 2 No Specify		Spe	Race - American I Black, White, etc. ecify: White	
Baltimore, Maryland 21215-0036	ed within 72   ygiene. ier than "nat t, the Medica	Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) 12  (Give life. L Secre	lent's Usual Occupation kind of work done during mos O NOT use retired) tary	st of working	John	f Business/Industr	s Hospita
/land	d d d	To Be	17. Father's Name (First, Middle, Last) Alexander Varinski			Middle, Maiden Surn Chojnowsk		
Mar	s 1 and 2 should of Health and Mer Item 27 is marke other traumatic		l =	g Address (Street and Numb Deviation Ro		Number, City or Ton		
imore,		32	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	sition (Name of natory or other place)	Date 8/16/2008	20c. Locatio	ium, Mar	State
Ball	permit. Page Department of Important: If any injury or once.			Name and Address of Facili				k Road
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	er the mode of dying, such as	s cardiac or respira	tory arrest,	Inte	proximate erval Between set and Death
Jo .	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unexactor Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):					
68760,	ncate be physicia s the bur	dical	d					
O. Box	requires that the death certificate been signed by the attending physionid be detached for use as the I	Physician/Me		Ectopic pregnancy Other (specify)			Date of delivery Month Day	Year
ords, P.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I	I. 23e.	Did tobacco use co		ause of death?
I Kec		e Completed by	25. Was case referred to medical	00.0	1 🗆	autopsy performed? Yes 2 🔼 No	b. Were autopsy to prior to comple death? 1 □ Yes 2 🕊	etion of cause of
OT 0	this cer al direct	To Be	examiner? 1 ☐ Yes 2 ☒ No  Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient	3 □ DOA Other: 4 □ Ni	e of Death <i>(Check</i> ursing Home 5	only one) Residence 6 □0	Other (Specify)	
NISION	to the noopstal of Atendang Prlysician; Ine law within 24 hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 of the property of the funeral director, page 2 of the funeral director.	Certification:	27. Manner of Death  1 ★ Natural  2 ☐ Accident  3 ☐ Suicide  4 ☐ Homicide  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)  28b. Time of Injury 28b. Place of Injury - At home, farm, stre	28c. Injury at Work?  M 1 □ Yes 2 □ et, factory, office	No 28f. Loca	cribe how injury occ tion (Street and Num or Town, State)		ute Number,
:	le nospital of 24 hours affile Euneral Di	Medical Cer	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death form one in the property of the p	occurred at the time, date an estigation, in my opinion, dea	nd place, and due:	to the cause(s) and	manner as stated	d. cause(s)
	within comp	Me	29b. Signature and title of certifier  ACITYW IT. WUND FITHING	29c. License number	327		ned (Month, Day,	
	U		30. Name and address of person who completed cause of death (Item 23a) (Type, F DY. GIZAW WOXENIWST GOOD FRANKLIN SQUA	rint) H Drive Balt	more Mi	21237		
	Stat Registra		DV. GIZAW WOXENIWST 9000 Franklin Squa 31. Date filed (Month, Day, Year) AUG 1 1 2008					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** AUGUST 6 FLORENCE MAE CAPEROON 2008 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5617 HARBOR VALLEY DRIVE BALTIMORE N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛱 F 219-22-9595 81 Yrs Director 14 1927 MARYLAND Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examinar must be notified at MD Director BALTIMORE 1)X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 5617 HARBOR VALLEY DRIVE Funeral 21225 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ∐Yes 2√ No If Yes, GiveA Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. þ Specify: WHITE 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR FACTORY is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be WILLIAM M. CLARK DAISEY CELESTE FITZPATRICK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau once. CELESTE MILEY 5617 HARBOR VALLEY DRIVE BALTIMORE, MARYLAND 21225 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL 4 Donation 5 Dother (Specify) AUG. 11 2008 BALTIMORE, MARYLAND 22. Name and Address of FacilitMCCULLY POLYNIAK FUNERAL HOME PA 21. Signature of Funeral Service Licensee 130 E. FORT AVE. BALTIMORE, MARYLAND 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown ditions contributing to death but not resulting in the underlying sause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 00 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vital 1 □ Yes 2 🔽 2 No 1 ☐Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 UNO Other: 1 ☐ Yes 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

Harjit Singh M.D.

29b. Signatura

5410-A Ritchie Highway, Brooklyn Park, Maryland 21225
Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1- For Amend 19a,	per FH G8	82 8/	11/08 <sub>e</sub> ;	tifica	ate of	neaith and Death	Menta	ai riyyie Reg				
	Dhusisi		1. Decedent's Name (First, Middle, La								ite of Death	Day	Year	3. Time of Death	
	Physici /Medio		Chrisoula Dra	cos							igust	ריים	2008	12:15 4	M
	Examin		4a. Facility Name (If not institution, given		)		4b. Ci	ty, Town, o	or Location of Dea	ith	1	4c. Count	y of Death		
			Johns Hopkins	Bayview			Ва	ltime	ore						
	Funeral		5. Social Security Number 6. S	Sex 7. A		last birthday)	If Un	der 1 Year	If Under 24 Hr Hours Mir	s. 8. Da	te of Birth onth, Day, Y	aar)	9. Birthp	lace (State or Fore	ign
	Director		213-28-2763	□ M 2 <b>X</b> F	85	Yrs.		Dayo	110010		2-24-			Greece	
	p z		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	nation							0d, Inside City Lim	
	aryla shor	5	Tod. State		100. 01	y, town or Lo	Cation							od. Inside City Lim 1 <b>⊡X</b> Yes 2 ⊡ f	
	Ne M	ecto	MD		Ba.	ltimor									-
	with t	Ö	10e. Street and Number					Zip Code	_				What Cour	itry?	
	s 23g	Funeral Director	516 S. Umbra S		. =			2122				USA			
	er de Item	, n	11. Marital Status	12. Was Deceden Armed Forces	?	.S. 13. V	Yas De Yes, s	pecify Cub	Hispanic Origin? ( an, Mexican, Pue	specify Y irto Rican,	es or No- etc.)		ce - Americ ick, White,		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced	1 Tes 2 In 1 Yes 2 In 1 Yes, Give Year or Dates:		1	□ Yes	2 <b>X</b> No	Specify:			Speci	∌: Whi	.te	
21215-0036	filed within 72 hours after death with the Maryland thygiene. ther then "naturel", or Items 23a or 28a-f show int, the Madical Examinar must be notified at	ed	15. Decedent's E	L		16a. Deced	ient's U	sual Occur	nation		16	h Kind of F	Business/Inc	dustry	
15	n "ne	Completed	(Specify only highest gr	ade completed)		(Give	kind of	work done use retire	during most of w	orking	10	D. 7411.G OF E	700000	203117	
212	with iene.	E	Elementary/Secondary (0-12)	College (1-4or	5+)		SA	amsti	race			C.	lothi	na	
	filled I Hyg othe	Be C	17. Father's Name (First, Middle, Last	)			00	ams c.	18. Mother's Na	ame (First	, Middle, Ma.			119	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.	To B	George Bonikos	5					Unkno	wn 7	Athana	asia			
ary	shound N		19a. Informant's Name/Relationship Angelopu	Type, Print)		19b. Mailin	g Addre	ess (Street	and Number or F				, State, Zip	Code)	
	nd 2 alth a 27 ts		Chris Angelope	ios <del>ilus</del> - Nei	ohew	616	S	Rani	nolla s	+	Balt	imore	, MI	21224	
imore,	s 1 a if Hei item othe		20a. Method of Disposition	•	20b. P	lace of Disposemetery, crem	sition (f	lame of	polla S	Date	20	c. Location	- City or To	wn, State	
E	Page ent c nt: If ry or		1 Surial 2 Cremation 3 Donation 5 Other (Speci		∌ I				tery 8-	11_0	)8 B	altin	nore.	MD	
Ë	artm orter inju		21. Signature of Euneral Service Lice												
	Per Per Per Per Per Per Per Per Per Per	21. Signature of Euneral Service Ficensee  Pradley-Ash  Bradley-Ash									nton	Fune	eral Hom	ıe,	
			PA, 2134 Willow Spring Road  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										Approximate		
	Physician		shock, or heart failure. List only Immediate Cause (Final	_	ent	:0								Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or a										years	
	Examiner			200 10 (01 2	3 4 0011304	201100 01).									
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a conseq	uence of):							-		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
ń	exec in an ial-tr	Еха	resulting in death) Last	Due to (or a	s a conseq	uence of):									
68760,	icate be executed physician and the burial-transit	cal		d											
68	tificat ng phy as th	Physician/Medical													
Вох	eath cer attendin for use	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			1 <del></del>					23d. Da	ate of delive	ery	
	death e atte	icla	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant				pregnancy (specify)	y 			M	onth	Day Year	
P.0	t the by th ache	hys	9 Unknown	9□ Unknown		·									
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions	contributing to death	but not res	ulting in the un	derlyin	g cause giv	en in Part I.	2:	3e. Did tobac	co use con	tribute to th	e cause of death?	
ecords,	w require been sig should b	edi									1 🗌 Yes	2 No	3 🗌 Prob	ably 4 □Unknov	wn
00	s bee	Completed								24	4a. Whasan	24b.	Were auto	psy findings availal	ble
$\alpha$	sicien: The law certificate has b lirector, page 2 s	шо									autopsy performe		death?	npletion of cause of	of
Vital		a	25. Was case referred to medical						26. Place of De			No	1 Yes	2 No	
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of			27. Manner of Death	28a. Date of Inj (Month, D		28b. Time of		28c. Injur Wor			escribe how				
ion	Attending r death. sctor; Afte	atlo	1 Natural 5 ☐ Pending 2 Accident investigation		ay rear)	Injury	М		rk?  Yes 2∐No						
Division	Atte	Certification:	3 Suicide 6 Could not be determined	289. Place of II	njury - At ho	ome, farm, stre	et, fact	ory, office					ber or Rura	l Route Number,	
á	s afte	Sert	4   Homeda	bullding, e	tc. (Specif	Y)				CI	ty or Town, S	itare)			
	Spit hours inere y fille		29a. Certifier 1 Certifying Pl	nysicien: To the bes	t of my kno	wiedge, death	occurr	ed at the tir	me, date and plac	e, and du	e to the caus	e(s) and m	anner as st	ated.	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	Medical	(Check only 2 Medical Exa	miner: On the basis and manner s	ot examina tated.	tion and/or inv	estigati	on, in my o	opinion, death occ	curred at the	he time, date	and place,	and due to	the cause(s)	
	To the To the Comp	Σ	29b. Signature and title of certifier	P 0 -			1	29c. Licens	se number		29d.	Date signe	ed (Month,	Day, Year)	
			Zynsey.	2 Pu	nd	SUP		va	16768	4	a u	4ust	-7,	2008	
,	1		30. Name and address of person who	completed cause of	death (Item	23a) (Type, I	Print)	- 1				1 -1	- 1		
(	l		30. Name and address of person who	to MO. 5	5051	topkins	Bal	wew	orde.	bulh	more	, his	212	24	
	Sta		31. Date filed (Month, Day, Year)	2008 32. <b>Regis</b>	trar's Signa	ture	Mad.								

Susie prakas

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10e, perFH G882 8/14/08 TT
State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Dukes 15 2008 9:30p. Calvin 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Catonsville Caton Manor Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours **1**√2 M 2 □ F 216-86-8854 Director 44 MD 08 16 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Exa<u>miner must be notifled at</u> 1 X Yes 2 No Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hills U.S.A. 21117 17 Enchanted Holls Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12th grade College (1-4or 5+) Construction Co. Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be Roxic Dukes Randolph Carter ပ 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Enchanted Hills Road, Owings Mills, Md Loretta lemon-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, Md King Memorial Park 3/19/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses 22 Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart valure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SOUAMOUS CELL CANCER OF Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an installing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ADPROVED BY MEDICAL EXAMINER Due to for selections offi-Examine death certificate be executed burial-trar and CERTIFICATION Due to (or as a consequence of): Box 68760. physician Physician/Medical the as aftending asn. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 8 LUCUND INFECTION 2.00 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate Vital 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes -250 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division or After this 27. Manner of Death 28a. Date of Injury 28h Time of Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation the Funeral Director: After and the fulled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the within 2 29b. Signature and title of ce tifier 29c. License number 9 0 29d. Date signed (Month, Day, Year) D0062634 MD 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10802 MATEEN AWAN HICKULY RIDGE RD COLUMBIA MD 21044

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 8 2008

32. Registrar's Signature

		State of Maryland / Department of Health a  1 - State Registrar  Certificate of Death		ne 2008 25744
	siciar		2. Date of Death	Day Year 3. Time of Death
Exa Fune		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Control of Cont	urvie	4c. County of Death
Direct		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	9/25/194	Philadelphia, PA
the Maryl 28a-f sho	ż			1 □Yes 21⊈No
3a or	ءُ ا	10e. Street and Number 189 Ryan Road 21122	10g.	Citizen of What Country?
partition (e.g., Mary) land 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If then 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event. It Medical Exprinent that the first of the statement of the stat	by Finon	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Z I Z I 3-0 d within 72 ho giene. rr than "natur	patolamo	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2  Clerk	of working	b. Kind of Business/Industry  Courier
d be filed be tiled ental Hy ced othe	8	17. Father's Name (First, Middle, Last)  18. Mother	r's Name (First, Middle, Maid	
hould lid Men marke	Ę		rrie Fisher	
ind 2 stall are 27 ls		19a. Informant's Name/Relationship (Type. Print)  William T. Evinger - Brother  2402 Lake Avenue,		ity or Town, State, Zip Code)
or other		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or Town, State
Description Pages Department of Mportant: If It in Mportant if It in In In In In In In In In In In In In In		4 Donation 5 Other (Specify) Metropolitan Crematory		Lexandria, Virginia
Deperm any I	ouce		4 /	739 Baltimore Ave. yattsville, MD 20781
Physicia / / / / / / / / / / / / / / / / / / /	er Examiner	Due to (or as a consequence of):    Due to (or as a consequence of):	cardiac or respiratory arrest,	Interval Between
the death certification by the attending lacked for use as		JEFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify)   9   Unknown		23d. Date of delivery Month Day Year
quires tha quires tha en signed uld be det	2	a large significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the cause of death?
		25. Was case referred to medical	24a. Was an autopsy performed 1 Yes 2 1	
40	JO B	m examiner?	of Death (Check only one) rsing Home 5 ☐ Residence	e 6 ☐ Other (Specify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ertification:	27. Manner of Death 1	28d. Describe how in	njury occurred  et and Number or Rural Route Number,
Hospital 24 hours Funeral letely filled	edical Ce	υ	d place, and due to the caus th occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To th within To th	Me	≥ 29b. Signature and title of certifier 29c. License number	5-cf 29d.	Date signed (Month, Day, Year)
√ Regi	State strar	(1) (1) ( CODO , MAN JONES AND MAN AND	3-4 America	4 21035

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] [ ] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Yeer 2003 14:30 M /Medical Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 5 sex If Under 24 Hrs. Hours Min. Date of Birth Month, Day, Social Security No If Under 1 Year **Funeral**  Birthplace (State or Foreign Country) -28-1807 1 ☐ M 2 🔀 Days **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28e-f ehow other treumatic event, the Medical Examinar must be inclined at 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 16 et and Numbe 10f. Zip Code 10g. Citizen of What Country? Borough 2 should be filed within 72 hours after death: and Mental Hygiene. is merked other than "natural", or teams non-Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ZNo Specify. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (0-12) College (1-4or 5+) ame (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 item 27 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 Cremation Depertment of Importent: If it any injury or o ō 3 Removal from State ☐ Donation 5 ☐ Other (Specify) eme 21. Signatore of Funeral Service Licensee Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. g, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Cancer Physician Metastatic disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, γ 6- KC222 on & Dueise 1 ☐ Yes 2 ☐ No 3 Probably Be Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has autopsy performed Division of Vital 1 🗆 Yes 20 No 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Scribe how injury occurred 28b. Time of 28c. Injury at Work? After Hospitei or Attending 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident efter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 45757 9ws+ 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MCNELvan Baltenere EGYTERA (10) 21224 31. Date filod (Month, Day, Year) 32. Registraris Signature State 2008

Registrar

AUG

			1 - State Registrar			nd / Depa	artme		lealth and I Death		ntal Hy		008	2	5746
		T Y	1. Decedent's Name (First, Middle, La	ist)						2.	Date of Dea	ath Day	Yea		3. Time of Death
	Physici /Medic		Hilda M. Gray								Month 8/5	/2008			9:22 P M
	Examin		4a. Facility Name (If not institution, given	re street and number	)		4b. Ci	ty, Town, or	Location of Deatl	h			County of De	ath	
			Julia Manor				Hag	gersto	own			Wa	ashing	ton	
	Funeral			Sex 7. A 1 □ M 2 🖾 F	ge (In yrs.	last birthday)		der 1 Year Is Days	If Under 24 Hrs. Hours Min.	8.	Date of Birt (Month, Day	h , Year)	9. B	irthplac Country	e (State or Foreign
	Director		5/9-20-0408	ILM ZMF	86	Yrs.					9/11	/192	l Wa		ngton, DC
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	ty. Town or Lo	cation							10d.	Inside City Limits
	Aaryli sho	ō	MD Washingt	on		erstow									1 ☑ Yes 2 ☐ No
	28a-	ect	MD Washingt	.011	IIag	erstow		Zip Code			T	10a. Citiz	zen of What	Country	?
	with Ba or	0	325 Wakefield Roa	.đ					21740				ted St		
	hours after death with the Maryland turel', or Items 23a or 28a-1 show al Exament must be multied at	Funeral Director	11. Marital Status	12. Was Deceden	Ever in U	.S. 13.	Was De	cedent of H	ispanic Origin? (S in, Mexican, Puert	pecif	y Yes or No-		4. Race - An	nerican	Indian,
0	witter of	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 🔀						to Ric	an, etc.)		Black, WI	nite, etc	
<u> </u>	rei', c	l by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 L Yes	2 🔯 No	Specify:				Specify:	Wh	ite
21215-0036	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's U	sual Occup	ation during most of wor	rkina		16b. Kir	nd of 8usines	s/Indus	try
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7	be filed within 72 hours after death with the Marylan tal Hyglene. Id other then "neturel", or litems 23a or 28a-1 show event, the Medical Exammer ment be nytified at		8 17. Father's Name (First, Middle, Last	11	-	Но	mema	aker	18. Mother's Nar		Time Adjudulla		n Home		
Sur Sur		Be	Carl William King						Alta J					)	
Ž	should be and Menta marked umatic ev	70	19a. Informant's Name/Relationship			10h Mailie	na Addre	on (Straat	and Number or Ru						ode)
Maryland	d 2 sho th and 7 is ma trauma		Richard Gray / so						Road, Ha					_	100)
a,	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20b. F	Place of Dispo	sition (f	lame of		Date			cation - City		, State
Baltimore,	00-		1 🔀 Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		9	cemetery, crer rt Lin				11	/2008	Bro	ntwood	M	D
≣	permit. Pag Department Importent: I any injury o		21. Signature of Fugeral Service Lice		10				ss of Facility	/	2000				re Avenue
ñ	Depa Impo any is		1 Jack H			Ga	sch	s Fur	neral Hom	ne,	P.A.				MD 20781
			23a Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause	d the deat	h. Do not ent	er the m	ode of dyin	g, such as cardiad	corn	espiratory ar	rest,		Aj	pproximate terval Between
П	Physician		Immediate Cause (Final disease or condition	n		1.00								0	nset and Death
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П	Examiner		Sequentially list conditions	, Chro	Nic	ohst	YUC-	tive	Puln	n ou	lary 1	DUCE	2ase		275
	р <u>#</u>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consec	juence of):					0				1
9.	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C										-	
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×	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregna	ancy						2	3d. Date of c	lelivery	
XOR	atter atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	uldeath 3□		pregnancy (specify)					Month	Da	ıy Year
Ö	at the de by the a tached	nysi	1 Lyes 2 No 9 Unknown	9□ Unknown				, ,, _							
	The law requires that the site has been signed by th bage 2 should be detache	by PI	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlyin	g cause give	en in Part I.		23e. Did to	bacco u	se contribute	to the	cause of death?
Vital Records,	w require been sig should b										1 🗆 ነ	'es 2	]No 3□	Probab	ly 4 🔀 Unknown
ပ္တ	aw re	Completed									24a. Was				findings available
ř	The law cate has page 2 s	E									autop perfo. 1 🗆 Yes	rmed?	death		letion of cause of
Ta	Physicien: Th r this certificate rral director, pag	BeC	25. Was case referred to medical examiner?						26. Place of Dea	ath (C					
o -	Physicien: this certific ral director,	10	1 Yes 2 No	Hospital: 1 ☐ Inpati	ient 2 🗆	ER/Outpatier	nt 3	DOA Oth	er: 4 Nursing H	lome	5 🗆 Resid	ience 6	Other (S	oecify)	
	ding P h. After ti funera		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inj (Month, D	ury a <i>y Year)</i>	28b. Time of Injury	f	28c. Injun Worl	y at k?	280	d. Describe h	ow injury	occurred		
<u> </u>	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	ne -			М		Yes 2 No						
Division	or At fter d Direct in by	Certification;	4 Homicide determined		ijury - At h tc. <i>(Speci</i>	ome, farm, str fy)	eet, fact	ory, office		28f	. Location (S City or Tox			Rural R	oute Number,
_	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier Certifying P	hysician: To the bes	of multi-	audodae de-ti	h 000000	ad at the Co	no data cod al		d dua to the	201102/21	and masses	ne etal	
	Hos 24 ho Fun etely	edical	(Check only 2 Medical Exa	miner: On the basis and manner s	of examina	ation and/or in	n occum vestigati	on, in my o	ne, date and place pinion, death occu	urred	at the time,	date and	and manner place, and d	ue to th	e cause(s)
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and mainier 3			2	29c. License	e number			29d. Date	e signed (Mo	nth, Da	y, Year)
	- s - ö			205				DI	2723		C	8-	06-	201	12
	.0		30. Name and address of person who	completed cause of	death (Iter	п 23а) (Туре	Print)		6 7 6 5						
	10		Dr. Khalid Was	seem 11	26 01	pal Ct.	. Н	agers	town, MD		21740				
	Sta		31. Date filed (Month. Dav. Year)	2008 32. Régist	trar's Signa	ature	2848	2							
	Registr	ar	Δ1115 1 3	CUUU 6	A. Carlo	ST. ST.	The state of	-							

DHMH 17 Rev 1/2001

State Registrar 30. Name and

31. Date filed (Month, Day, Year)

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2008

AVENUE

MEDICAL

ress of person who completed cause of death (Item 23a) (Type, Print)

BASTERN

32. Registrar's Signature

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BATIMPE, MARYLAND

2008

			- State Amend Items Registrar	State of Marylan 25,27,28a-f	nd / Departmen per mer 1882	t of Health and e08/08/08dhb	Mental Hygi	ene2008	25748
	Physici /Medic		1. Decedent's Name (First, Middle, Last	den			2. Date of Death Month	20-2008	3. Time of Death
	Examir		4a. Facility Name (If not institution, give GPNCS) Ray S. Social Security Number 6. Se	dallstown	last birthday) If Under		town	4c. County of Death	MOPE (OUNTY place (State or Foreign)
	Director		218-26-0625 10 Usual Residence of Decedent	M 204	Yrs. Months	Days Hours Min.	Month, Day, January	30, 1926 No	the Carolina
	n the Maryland r 28a-f ehow	ctor	Maryland 10b. County	A 10c. Cit	ty, Town or Location	Battimore			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral Director	10e. Street and Number 1545 Cliffon	Ave.	10f. Zip	21217	10	g. Citizen of What Could A	ntry?
036		þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	I.S. 13. Was Deced If Yes, specific Yes.	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer 212 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Da	
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after of Heelth and Mental Hygiene. Item 27 is marked other then "natural", or Ite other traumatic event, the Medical Examina	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usur (Give kind of wo life. DO NOT u	rk done during most of wo se retired)	rking	Spring Grov Haspit	dustry 1e Hate tal
land	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last)  MOS.CS Willia	ims		18. Mother's Na	me (First, Middle, M	laiden Sumame)	
	and 2 should selth and Men n 27 le marke		19a. Informant's Name/Relationship (T. Alberta Leach	ypo, Print) -daughter	19b. Mailing Address	(Street and Number or Ri	Baltinor	City or Town, State, Zipe Marya	Code) 21217
altimore,	Pages 1 a nent of He int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Bamayal from State	Place of Disposition (National Commetery, crematory or Commetery)	ators 4	Date 2	Catonsville	own, State Maryland
Balti	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licens	Parker	22. Name at 3572	nd Address of Facility Pa Frederick A	Ker Fur	nore, Mar	P.A. 21239
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	dications that caused the deat one cause on each line.	th. Do not enter the mod	de of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
1	/Medical Examiner	er	Sequentially list conditions	. Subdur	quence of):  A hemo	atema		-VAMINER	
50 MC	sate be executed hysicien and the burial-transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Anoxic  Due to (or as a consec	brain i	yury CERTIFICATION	N POR OVED BY MED	ICAL EVI	
0 20 x	artificate t ing physie e as the b	Medical	IF FEMALE:	d					
Lor O. Box	The law requires that the death certific tie hes been signed by the attending p bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregni 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 Ectopic p			23d. Date of deliv Month	ery Day Year
rds, P	quires that in signed b uld be deta	δ	Part II. Other significant conditions co	entributing to death but not res	sulting in the underlying o	cause given in Part I.		acco use contribute to t s 2 □ No 3 □ Prof	. /
Division of Vital Records,	The law requir ate hes been si page 2 should	Completed					24a. Was an autopsy perform	ied? death?	opsy findings available ompletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	ath (Check only one		20110
of	Phys this ral dii	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	28b. Time of Injury 2	DA 4 Z Mirsing I 28c. Injury at Work?	dome 5 Resider	nce 6 Other (Speci w injury occurred	fy)
isior	al or Attending is after death. I Director: After d in by the fune	icatic	1 ☐ Datural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	01/10/08	Unknown <sup>M</sup>	1 ☐ Yes 2X No	28f Location (Str	fell down	al Route Number
Div	F & F C	Certification:	4 Homicide determined	Home Home	fy)		Baltimor	ce, MD	ifton Ave.
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier  (Check out) one)  1 Certifying Phy 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as s ite and place, and due t	stated. to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of contribution	The mo	MD11 1	c. License number	29	d. Date signed (Month,	Day, Year)
			30. Name and address of person who d	completed cause of death (Iter	m 23a) (Type, Print)	1 1 641		4-21-	LUO
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	9109 L	iberty Ko	ed, Ko	andalls to	on MD 2/122
	Registi		AUG 0 8 2008	Alder as It	Sparke				-(1))

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician Marian L. Hayes 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Catonsville Manor Care-Woodbridge Valley Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Dec.28, 1918 Maryland Director 212-09-3201 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exandrum must be notified at 1 ☐Yes 2 X No Director Catonsville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21228 1916 Beverly Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Specify: White 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Ş 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hallie D. McFarland William H. Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2058 Bandy Avenue; Eldersburg, MD 21784 Anne Davis Executor Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/9/2008 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LIVER CIRMOSIS ALCOMOLIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in models cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner death certificate be executed ling physician and e as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the attending IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year ō Day 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>^</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes 2 No 1 □Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0059107 -06-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS REIGTERSTOWN,

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

LENTER

32. Registrar's Signature

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				ase Type or P State of				. Ensure A Health and N	_		gible.			
			1 - For State Registrar			•	tificate of		R	eg. No.	2008	25	750	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  MILTON		KLEIN				2. Date of Deat Month AUGUST	Day 6	2008	3. Time of D 2:00A	Death M	
	Examin	er	4a. Facility Name (If not institution, give street and number)  1 SLADE AVENUE, APT. 706				4b. City, Town, or Location of Death  BALTIMORE			4c. County of Death  BALTIMORE				
	Funeral Director		5. Social Security Number 213–28–7666			Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.			8. Date of Birth 06/29/1915  9. Birthplace (State or Foreign Country) NY			Foreign		
	0		Usual Residence of Decedent  10a. State 10b. Count		10c City	Town or Lo	cation			-		0d. Inside City	Limits	
	a-fsho	ctor	MD BALTI	,		BALTI						1 □ Yes 2	Z∑No	
	n with the	To Be Completed by Funeral Director	10e. Street and Number 1 SLADE AVENUE, APT. #706				10f. Zip Code	1	10g. Citizen of What Country? USA					
5-0036	within 72 hours after death with the Maryland ene. I than "natural", or items 23a or 28a-f show he Modical Evaniner must be notified at		11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates:			i	13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ▼ No Specify:				o- 14. Race - American Indian, Black, White, etc.  Specify: WHITE			
0-6121			15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			(Give life. L	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  PRESIDENT				16b. Kind of Business/Industry  FOOD MANUFACTURING			
nd 2	be filed within ntal Hygiene.		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle,				, Maiden Surname)			
Maryland			HARRY	atria (Tana Baiat)	K.	LEIN	- Add (Ohn-sa	ANNA	- L Double Museline		NOWN	0-4-1 04.0	20.4	
	127 mg d		19a. Informant's Name/Relation LLOYD MAILMAN					and Number or Ru						
altımore,	0 0		20a. Method of Disposition  1 △ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (		late		sition (Name of natory or other pla	1			on - City or To			
Balti	permit. Pag Department Important: I any Injury o		4 Donation 5 Other (Specify) HEBREW FRIFNDSHIP 08/08/2008 BALTIMORE, MD  21. Signature of Funeral Service Ligensee 222. Name and Address of Facility SOL LEVINSON & BROS., INC.  8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208											
1	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  Approximate Interval Between Onest and Death UK											
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):								year			
	cuted nd ansit	Examiner												
2,60,	ate be executed nysician and he burial-transit	ca												
O. Box 68	w requires that the death certificate there is green signed by the attending phys should be detached for use as the I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown							23d. Date of delivery Month Day Year				
. Y.	requires that the seen signed by th hould be detache	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did toba							accoluse contribute to the cause of death?				
	law requ as been 2 should		O WONES C	Containe Orbitador Orbert				2			a. Was an autopsy findings available prior to completion of cause of			
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	or the Hospital of Attending Prhysician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital:	patient 2 ☐ E	R/Outpatier	nt 3 DOA Oth	er	th <i>(Check only on</i> ome 5 <b>∑</b> Reside		Other (Specif	·v)		
on or		tion: T	27. Manner of Death  1 Natural 5 Pendi 2 Accident invest	28b. Time of Injury	me of 28c. Injury at 28d. Describe how injury occurred									
DIVISION		Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, 1 building, etc. (Specify)								(Street and Number or Rural Route Number, wn, State)			
		Medical C	29a. Certiffer (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  105769  29d. Date signed (Month, Day, Year)											
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Once I was the first of Tower, who is the person who completed cause of death (Item 23a) (Type, Print)											
ĺ		State Registrar  AUG 1 1 2003  32. Registrar's Signature												

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nald Morrison			State of Marylar	nd / Depart	tment of	Health ar	nd Menta	al Hygiene				
	P	- For State egistrar		Certi	ficate of I	Jeath		2. Date of I	Reg. No.	3. Time of Death		
Physicia	-	. Decedent's Name (First, Mid						Month	Day Year 7, 2008	1746 hrs		
f 'Examin		la. Facility Name (if not institut	Morris	ober)	45	. City, Town, o	or Location of		4c. County of De	eath		
		Good Samaritan Hos		11501)		Baltimore						
Funeral		5. Social Security Number	·	7. Age (In yrs. last	t birthday)	If Under 1 Ye	ear If Under	24Hrs. 8. Date o	f Birth (MM/DD/YYYY) 9.	Birthplace (State or		
Funeral Director			1 -W 2 F	61	Yrs.	Months Da	ays Hours	Min. 2.8	21.1957	oreign Country)		
	9	219-66-5708 Usual Residence of Decedent		DI						7.443		
aux		10a. State 10b. Count	:y	10c. City, T	own or Locatio	n				10d. Inside City Limits		
		CIAA		Br	altim	ore.				1 Tes 2 No		
Maryland 28a-f show d at once.	윐	10e. Street and Number	<u> </u>			10f. Zip Code		- 1	10g. Citizen of What			
ith the Maryland 23a or 28a-f sho notified at once.	Director	710 Beave	r Brook	2		21212	L		U.S.	A		
with t	曺	11. Marital Status	12. Was Dece	edent Ever in U.S		Decedent of I	Hispanic Origi	n? (Specify Yes o Puerto Rican, etc.		merican Indian, Black,		
eath r item	Funeral	1 Never Married 2	Married Armed Fo	2 LHG	II Ye	s, specify Cub	ian, Mexican,	ruelto Ricali, cto.	,			
after of	D F	3 Widowed 4	Divorced If Yes, Give Year or Dates:			Yes 2			Specify:	Black		
5-0036 led within 72 hours a Hygiene. other than "natura in Medical Examin		15. Decedent's Education (S			16a. Decedent during mo	's Usual Occup st of working li	pation (Give k ife. DO NOT u	ind of work done use retired)	16b. Kind of Busin	ess/industry		
6 n 72 h an "r		Elementary/Secondary (0-12) College (1-4 or 5+)			7	`	N .:		Pepsi			
5-0036 led within 7 Hygiene. I other than		17. Father's Name (First, Middle, Last)				ruck	18.Mother's	Name (First, Mid	(First, Middle, Maiden Surname)			
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21215-0036 Juld be filed within 72 Mental Hygiene. marked other than ic event, the Medical		William  19a. Informant's Name/Relation	onship (Type, Print )	014,01.	19b. Mailing	Address (St	reet and Num	ber or Rural Route	Number, City or Town,	State, Zip Code)		
O 용 된 호 플	-	Deborah		a-Costie	2008	3 Ne	w Hav	en Dr.	3altimore	M) 21221		
Baltimore, ML pemit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	ı	20a. Method of Disposition	11/	20b. P	lace of Disposi rematory or oth	tion (Name of	cemetery,	Date	20c. Location - Ci	ty or Town, State		
Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr		1 Surial 2 Crema					meich	8.14.2	we Balti	(M. szm		
Itin Pair Partiment ortan	- 1	4 Donation 5 Other 21. Signature of Funeral Serv	Specify: ice Licensee		22. N	ame and Addr	ess of Facility	Variabo	C. Greene	funeral services		
Balti permit. Departir Imports injury o		Varan a	hamo		40	105 V	ock Pro	d Adlic	nore, MD	21212		
hysician		23a. Part I. Enter the disease	, or complications that c	aused the death.	Do not enter th	ne mode of dyin	ng, such as ca	ardiac or respirato	ry arrest, shock, or heart	Approximate Interval Between Onset and		
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xaminerی		Immediate Cause (Final disease or condition resulting in death)  a. Complications of hepatic cirrhosis  Due to (or as a consequence of):										
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e exe	dical	X UNPENDED	AMENDED	23a,27,p	eim, E	3002 07	20/00	11				
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68° certifi nding se as	ian	past 12 months?		pirτη nant at time of dea		tal death her (Specify)	5	o programo,		,		
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that the dened by the detached is		Part II. Other significant con	nditions contributing t	to death but not re	esulting in the u	underlying cau	se given in Pa			ute to the cause of death?		
ords, P.O. w requires that t as been signed by	d by									Probably 4  Unknown		
ds, equir	ete							24a.		ere autopsy findings available or to completion of cause of		
COr law 1 has be 2 sh	Completed								performed? de	eath? ✓ Yes 2 No		
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  "In Director: After this certificate has been silled in by the funeral director, page 2 should t		25 Was case referred to me	dical			26.P	Place of Death	(Check only one)				
Vital ysician his ceri	Be C	examiner?	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other:									
n of V Jing Phy After th funeral d	٠. ت	1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury	28b. Time of	Injury 28c.	Injury at Wor	k? 28d. Des	scribe how injury occurre	d		
on ( anding ath. rr. Ad	흲	1X Natural 5 Pending (Month, Day,Year) 1 Yes 2 No										
VISION or Attendifier death Director:	fica	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc.										
Division pital or Attent ours after death erral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) or Town, State)										
Hospi 24 hou Funer tely fi										as stated.		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the funeral Director: After this certificate has been signed by the attending physt completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check only onle)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
F § F 8	₩ B	29b. Signature and title of certifier				29c. License number			29d. Date signed (Month, Day, Year)			
de la company		Janate & surthall mo					C.M.E.	C.M.E. August 8, 2008				
Hepo!		30. Name and address of person who completed cause of death (Item 23a)  Pamela F Southall MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
1 ~		Pamela E. Southa	·	t Medical Exa		11 Penn St	reet, Baltir	more, MD 212				
S	tate	31. Date filed (Month, Day, Y	(ear) 32. F	Registrar's Signati	ure	.4						

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 🕞 🛭 🥄 1 - For State Registrat Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** 4:40 PM 08 DRGAN METAL /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MALIOR MURSTUGATEH BAL TIMORE KEDGELWAY 8. Date of Birth (Month, Day, Year)
Oct. 26, 1 Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year **Funeral** 1□M 2**9**F Days Min Hours 94 213-05-0139 Yrs 1913 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or Items 23s or 28a-f show treumetic event, the Madical Examiner trust be notified at 1 ☐ Yes 21 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 16 S. Beaumont Avenue USA death Funerai 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Coordinator Limestone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James W. Morgan Agnes Heiderich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) M. Bernadette Morgan Sister 16 S. Beaumont Avenue; Catonsville, MD 21228 othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 8/8/2008 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Diceasee Moto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Inaution ew weeks disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner en veek septie Shoch Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the at Id be detached for ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2∏ No 2 🗆 (No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred of or Attending Parter death. After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di completely filled in 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of earlier 29c. License number Dr. Chuanty) Aug 7, 2008 122541 Man deyor MI) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOllins feny Rd, Site 4A, Baltiner, MD 21227 RAJA MD 14367 31. Date filed (Month, Day, Year) \$2. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 257 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Vornell Gene Mitchell, Sr. **Physician** July 30, 11:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5958 Daywalt Avenue Baltimore N/A 8. Date of Birth (Month, Day, Year)
Feb. 5,1941 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 219-32-6802 7. Age (In vrs. last birthday) Funeral XXM 2□ F Months Days Hours Min. 67 Yrs. Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notified at N/A MD Baltimore XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5958 Daywalt Avenue 21206 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 📈 No Specify: þ Specify: Black 3 ☐ Widowed 4 █ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Metal Masters than " Elementary/Secondary (0-12) 8th Grade permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, I'm. M. College (1-4or 5+) of Baltimore Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Bunyon Mitchell Mary Ella Wright 19a. Informant's Name/Relationship (Typp. Print)
Denise Mitchell/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 822 Ridgeview Road Baltimore, Maryland21225 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages ' 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Zion Cemetery 8/6/08 Lansdowne, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 Jarres 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 118. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner day, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical the nding p IF FEMALE: nse s 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery atter for u 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 Tyes 2 TNo 9 Unknown signed by I pe deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by Imono 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page perform certificate 2 🗆 No 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After thi funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? Division 5 ☐ Pending investigation ours after death.

neral Director: At filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

'Registrar

State

Name and address of

31. Date filed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

		í	1 - For State Registrar	State of Ma	ryland / Dep Ce	artment of F ertificate of			giene 0	08 25755	
	Obverial		1. Decedent's Name (First, Middle,	Last)		-		2. Date of De Month	ath Day	3. Time of Death	
	Physici /Medic		Alice			Morgan		ALKILLY		10:00 AM	
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	Location of Deat	h	4c. County	of Death	
			Anne Arundel Ge	neral Hospi	tal	Annaı	olis		Anne	e Arundel	
	Funeral		5. Social Security Number 6	Sex 7. Age 1 M 2 M F	(In yrs. last birthda)	Months Days	If Under 24 Hrs. Hours Min.		th y, Year)	Birthplace (State or Foreign Country)	
	Director		145-20-3770	1 2 W 2 W 1	81 Yrs.			Jan. 2	7,1927	Florida	_
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or I	ocation				10d. Inside City Limits	
	Aaryl Feho	ь	M 1 1 A	1	Class Par	um i a				1 ☐ Yes 2 No	
	28e-	Director	Maryland Anne A	runder	Glen Bu	10f. Zip Code			10g. Citizen of	What Country?	_
	with se or					2106	50		U.S	-	
	ne 23	Funeral	1 Forest Road	12. Was Decedent E	ever in U.S. 13	Was Decedent of H	ispanic Origin? (S	Specify Yes or No		e - American Indian,	_
0	r Iter	표	1 ☐ Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 ី N		If Yes, specify Cuba	in, Mexican, Puer	to Rican, etc.)	Bla	ck, White, etc.	
21215-0036	d within 72 hours after death with the Maryland jaene. r then "natural", or Iteme 23a or 28e-f ehow The Madical Examinar must be natified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specif	White	
2	72 ho	Completed	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occup	ation	dring	16b. Kind of B	usiness/Industry	
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7	ed wi	S	12	N/A		Self Emp			Beaut:		
2	be filed hal Hygie d other	Be (	17. Father's Name (First, Middle, La	ist)			18. Mother's Nar	ne (First, Middle,	_		
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Maryland	es 1 and 2 should b of Health and Ment of Item 27 is marked r other treumatice		19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street	and Number or Ru	ural Route Numbe	er, City or Town,	State, Zip Code)	
	and ealth m 27		Fred Morgan (Hus	sband)	1 F	orest Road	d Glen Bu				_
Baltimore,	of H		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	☐Removal from State	cemetery, cr	osition (Name of amatory or other place	e)	Date	20c. Location	- City or Town, State	
Ē	permit. Pages 1 Department of H important: If ite ony injury or ot		4 ☐ Donation 5 ☐ Other (Spe	cify)	Bayview	Cremator	08/1	11/08	Baltime	ore, Maryland	
Ša	epari epari npor ny in		21. Signature of Funeral Service Li	censee	3	22. Name and Addre	ss of Facility	Tuneral	Home, P	. A .	
_	40 = 9 d		Jak 1	gr-		3204 Moun	ain Road	i Pasade	na, Mar	.A. yland 21122	
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	mplications that caused ity one cause on each lin	the death. Do not e	nter the mode of dyin	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between	
}	Physician		Immediate Cause (Final disease or condition	ACUTE	myeck	MDIAL	INFARC	TION		Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):						
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	and and	xan	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):						-
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×	ires that the death certificities signed by the attending doe detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d Da	ate of delivery	
X Q Q	atter I for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		☐Ectopic pregnancy ☐ Other (specify)				onth Day Year	
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1	requires that the een signed by th hould be detache	Y P	Part II. Other significant condition	s contributing to death bu	it not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to the cause of death?	
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ecor	~ 0 70	ete						24a. Was	an 24h	Were autopsy findings available	-
e E	The law cete has b page 2 sl	Completed						autop	rmed?	prior to completion of cause of death?	i
VII	icien: Th certificete rector, pag	C	25. Was case referred to medical					1 Yes		1 ☐ Yes 2 No	4
	Physicien: this certific ral director,	O B	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ZER/Outpatie	ent 3 DOA Oth	or	ath (Check only o			
ō	Phys or this oral di	- +	27. Manner of Death	28a. Date of Injury	y 28b. Time	of 28c. Injur	at	lome 5 Resident	now injury occur		-
0	ding Ph th. : After thi s funeral	盲	1 Matural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day	Year) Injury	Wor	k? Yes 2 □ No		• ,		1
UNISION	Atter dea octor	fica	3 Suicide 6 Could no	t be 28e. Place of Inju	ry - At home, farm, s	treet, factory, office				ber or Rural Route Number,	-
S	spital or Attenions after deat ours after deat lerel Director: filled in by the	Certification:	4  Homicide determin	building, etc.	. (Specify)	,,		City or To	vn, State)		1
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying	Physician: To the best of	of my knowledge, dea	th occurred at the tir	ne, date and place	and due to the	cause(s) and m	anner as stated.	-
	ne Ho	edicai	(Check only 2   Medical Ex	caminer: On the basis of	examination and/or i	nvestigation, in my o	pinion, death occu	irred at the time,	date and place.	and due to the cause(s)	
	To the Hos within 24 h To the Fur completely	ž	29b. Signature and title of certifier			29c. Licens	a number		29d. Date signe	d (Month, Day, Year)	-
)			- mong	m		3	7531		Augu	St 06, 200 8	
	,		30. Name and address of per will	no completed cause of de	eath (Item 23a) (Type	, Print)			1		
(	0		29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of per with the second	, 8601 V	cterans	Musy.	Suite 2	204 2	rillers	rue, mo 2110	8
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	128					-
	Registr	ar	AUC 1 1 200	8 Later 1	15° 150000						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 U U 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 11:10 PM KATHERINE MURPHY August 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Joseph Nursing Home Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2□F Yrs May 19,1925 83 New York Director 054-20-6549 Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 1222 Tugwell Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene, item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Timothy Murphy Johannah Sweeney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Walker Avenue Baltimore, Maryland 21212 Mr. Daniel Murphy (Brother) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 4 ☐ Donation 5 ☐ Other (Specify) 8-11-08 Calvary Cemetery Queens, New York 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. of Funeral Service Licen M00344 6500 york Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complet tions the shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by an-throats 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number D34951 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vos Federile PO dite 100 Cotonor. 1/4 MD 21770 MAC mK 31. Date filed (Month, Day, AUG 1 1 State Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary	•	rtificate of D		iciliai i iy	Reg. No.	2008	257	757
	Physicia	an	Decedent's Name (First, Middle, Last)     Dorothy Nance		_			2. Date of De Month	Day	y Year + 2008	3. Time of D	
	/Medic		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or I	Location of Death	Aug.		4 2008 County of Death	10:45	A M
-40	LXaniin		3800 W. Belvedere A	venue Apt.	312		Baltimore					
	Funeral Director		5. Social Security Number 215-28-8115 6. Sex 1 □	M STAFE	yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da March 13	th 1 <i>y, Year)</i> 3 <b>, 1</b> 93	9. Birth Cou	place (State or intry) SC	Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation					10d. Inside City	y Limits
	Maryli -f sho	ţo	MD			altimore					1 X Yes	2□No
	with the	Il Director	10e. Street and Number 3800 W. Belvedere A	venue Apt	. 312	10f. Zip Code	21215		10g. Cit	izen of What Cou U	ntry? SA	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 St Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever Armed Forces? 1		Was Decedent of His f Yes, specify Cubar 1 □Yes 21☑No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No Rican, etc.)	)•	14. Race - Amer Black, White Specify: B		
15-0	72 hc "natur	letec	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual Occupa kind of work done du DO NOT use retired)	tion uring most of worki	ng	16b. K	ind of Business/li	ndustry	
121	filed within Hygiene. ther than int, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	homemak				domestic		
pu	be filed stal Hyg d other event,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden	Surname)		
ylaı	Mental Mental arked o	To E	John Nano					Eva McSwa				
	1 and 2 should Health and Mer em 27 is marke other traumatic		Joy A. Black / Daug	,		ng Address ( <i>Street</i> a R <b>Eisterstow</b> n					ip Code)	
Baltimore,	nit. Pages 1 artment of He ortant: If iten Injury or oth E.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Road Control	emoval from State	Ob. Place of Dispo cemetery, crer Metro Crer	sition (Name of matory or other place natory	08/07		Cator	ocation - City or T nsville, M		
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License	ee I		2. Name and Address 638 N. Gilmo				Home, P.A. ryland 21	217	
	Physician /Medical Examiner		25a. Part. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	L My nsequence of): Cran a	er the mode of dying  OCALO  Vy  A		,	-	h	Approximate Interval Betw Onset and D	veen
68760,	tificate be executed by physician and as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co		(						
O. Box	The law requires that the death certificat ate has been signed by the attending phyage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{\$\phi\$} \) No 9 \( \text{\$\subset\$Unknown} \)	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)				23d. Date of deli Month		'ear
rds, P.	quires that to an signed by uld be deta	by	Part II. Other significant conditions con	ntributing to death but no	t resulting in the u	nderlying cause give	n in Part I.		tobacco (	use contribute to		eath? Inknown
Vital Records,		Completed						24a. Was auto perfo	psy ormed?	prior to c death?	opsy findings a ompletion of ca	vailable use of
Vita	Physician: this certific ral director, I	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death					
of	ing Phys After this uneral di	ion: To	27. Manner of Death  1 Natural 5 Pending	1 ☐ Inpatient  28a. Date of Injury (Month, Day, Ye	2 ER/Outpatier  28b. Time of Injury	f 28c. Injury Work	at ?	me A Resi 28d. Describe		6 ☐Other (Spec ry occurred	ify)	
Division	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director. After this completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)		∕es 2 □No	28f. Location ( City or To	Street ar wn, State	nd Number or Ru e)	ral Route Numb	ber,
_	Hospital 24 hours a Funeral C	Medical Co		sician: To the best of m ner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my or	pinion, death occur	red at the time.	date an	d place, and due		)
	To the I within 2 To the I Complet	Med	29b. Signature and title of certifier	The memor stated.		29c. License	number		29d. Da	ate signed (Month	, Day, Year)	
	/		1 do			D2	5044		8/	568	-	
	2		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	29c. License D2 Print) Mondo R	Eny Re	/ 2	12	27		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 1 2008	32. Registrar's	Signature	Ed .						

DHMH 17 Rev 1/2001

		Ple	ase Type or Pri						_		gible.	
		For State	State of M	laryland i	•					0	000	25750
		Registrar  1. Decedent's Name (First, Mid-	dio Last)		Cei	rtificate	of Death	<i>,</i>	2. Date of Dea	Reg. No. Z	000	2 0 / 0 9 3. Time of Death
Physic			N. Pasc	oe					Month August	Day	Year 008	3:30 A M
/Med Exam		4a. Facility Name (If not instituti				4b. City, To	wn, or Location	of Death	August	1	nty of Death	J. 30 A
<i>i</i>		1482 Colony Ro					sadena	- 04 11 1		An	ne Arı	ındel
Funera		5. Social Security Number	6. Sex 7. A	Age (In yrs. last	birthday) Yrs.	If Under 1 Months E	Year If Unde Days Hours	r 24 Hrs. Min.	8. Date of Birtl (Month, Day	(, Year)		place (State or Foreign atry)
Directo	r	214-22-1082 Usual Residence of Decedent		85					Dec. 24	, 1922	Nori	h Carolina
ıryland show	_	10a. State 10b. Count	ty	10c. City, T	own or Lo	cation			-		1	0d. Inside City Limits 1 ☐ Yes 2 XNo
he Ma 28a-f	Director		e Arundel	Pas	adena					10g. Citizen	of Milant Cour	
with t		10e. Street and Number	a d			10f. Zip Co						iu y :
death ms 23	Funeral	1482 Colony Ros	12. Was Deceden	t Ever in U.S.	13.		21122 t of Hispanic O	rigin? (Sp	ecify Yes or No- Rican, etc.)	14. <u>F</u>	Race - Americ	
after or ite		1 ☐ Never Married 2 ☐ Ma	Armed Forces arried 1 ☐ Yes 2 ☐ If Yes, Give	<b>X</b> No		r Yes, specify 1 ∐ Yes 2 🖸			rican, etc.)	Spe	Black, White,	etc.
ural",	d by	3 Widowed 4 □ Divorce	ed Year or Dates								Business/In	nite
in 72 in mat	plete	(Specify only high	ent's Education nest grade completed)		(Give	dent's Usual ( kind of work ( DO NOT use (	done durina mo	st of worki	ing	100. Kind of	Business/in	dustry
filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or items 23a or 28a-f show ent, its Modical Exp. nit or must to rotified at	Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)		Cook				Res	taurar	)t
d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Examinant must be reallies at	Be C	17. Father's Name (First, Middle	e, Last)				18. Moth	ner's Name	e (First, Middle,			
2 should be and Mental is marked or	임	Dewey			nson			1ton				swell
d 2 st d 2 st lth and 27 is n traun		19a. Informant's Name/Relation				,			al Route Numbe	-		
s 1 and 2 if Health a item 27 is		Nick R. Funkho 20a. Method of Disposition		20b. Plac	e of Dispo	Sition (Name natory or other	Koad J	Pasad	ena, Ma Date	ry Land 20c. Locatio	21122 on - City or To	own, State
Pages nent of int: If it		1 🏋 Burial 2 □ Cremation 4 □ Donation 5 □ Other		e			n. Pk.	08/1	1/08	E1krid	ge. Ma	ryland
permit. Pages 1 and Department of Health Important: If item 27 any injury or other to	ġ	21. Signature of Funeral Service	e Licensee	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	22	2. Name and	Address of Faci	lity				
1 205 8 5	Öl 💮	1-917	M		[	3204 Mc	ountain	Road	uneral l <del>Pasade</del> :	nome, n <del>a, Ma</del>	ryland	21122
		23a. Part T. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	or complications that cause ist only one cause on each	ed the death. I	Do not ent	er the mode o	of dying, such a	is cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physiciar /Medica		disease or condition resulting in death)	a. ORDI	NARY /	HRTE	ey D	128425	•				yes
Examine	r		b but to (or a	as a consequen	ice oi).							
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequen	ice of):							
e be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c	as a consequen	ice of):					_		
eath certificate be exattending physician for use as the buria			d		,							
rtificat ng phy as the	Physician/Medical											
ath cer tendir	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth	ne of pregnancy n 2 🗆 Fetal de		☐ Ectopic pre	gnancy				Date of deliv	ery Day Year
the at hed for	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	t at time of deat n	th 5	Other (spec	ify)				Month	Day Teal
that the dended by the a		Part II. Other significant condi	itions contributing to death	but not resultin	ng in the u	nderlying cau	se given in Part	: I.	23e. Did to	obacco use c	ontribute to t	he cause of death?
w requires that the death certificate is been signed by the attending physishould be detached for use as the I	d by	CONGESTIVE HEA	ART FAILUR	E, PP	KEN	AXER	FORS	ICK	1 □ Y	es 2 No	3 □ Pro	bably 4 🗌 Unknown
	Completed	SINUS SYNDER	om E, CARDI	0/40/	AT19	14, C	4PONIC		24a. Was	an 24	b. Were auto	ppsy findings available
The The ate has page	Com	ATRIAL FIBR	LILLATION C	EREBR	OVA	SC DIS	SPASE	,		med?	death? 1 ☐ Yes	mpletion of cause of
Physician: Tribis certificate ral director, pa	Be	25. Was case referred to medic examiner?					T	ce of Deat	h (Check only o	ne)		
Phys rthis ral dir	7: T	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of Ir	atient 2 ER	I/Outpatier  Bb. Time o			Nursing Ho	ome 5 Residence 128d. Describe h			fy)
Attending F r death. ector: After by the funer	ation	1 Natural 5 ☐ Pend		Day, Year)	Injury	м	. Injury at Work? 1 ☐ Yes 2 ☐	□No	20d. Describe i	ion injury oo	Junou	
Attendi	Certification:	3 ☐ Suicide 6 ☐ Coul	rmined   28e. Place of I	njury - At home etc. (Specify)	e, farm, str	eet, factory, o	ffice		28f. Location (S		mber or Run	al Route Number,
ital or als after ral Dir												
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		ying Physician: To the bes al Examiner: On the basis and manner:	of examination								
To the within 2 To the comple	Me	29b. Signature and title of certif				29c. l	icense number	,		29d. Date sig	ned (Month,	Day, Year)
~		Dorame	module	1 M	)		D2161	3		8/7/	08	
10		30. Name and address of person	on who completed cause of	death (Item 23	3a) (Type,	Print)	01 0	head	212 2 1 =	20 -7	1127	
9	tate	31. Date filed (Month, Day, Yea	aley O4H 7	strar's Signature	e J	seach	KOL. M	1 XICI	ena, n	100	1100	
'Regis		AUG 1	1 2008	Wer A	2 1	100 M 3						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Job 8 Month :38 AM **Physician** EDWARD **PETERS JAMES** WRUST /Medical 4a. Facility Name (If not institution, give street and number) 0 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BURNIE BALTIMOREL ARUNDEL PASHINGTON MEDICAL GLEN ANNE CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. | April 14, 6. Sex. 1 M 2 ☐ F 7. Age (In yrs. last birthday) 73 Yrs. 9. Birthplace (State or Foreign **Funeral** Year) 1935 Months 218-30-5089 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaninat must be notified at 1 ☐ Yes 2 No Director Marvland Anne Arundel Glen Burnie 425 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7466 East Furnance Branch Road Apt. 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∄Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐Yes 2 No Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Warehouseman Maryland Glass Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Peters Keefe ပ္ Robert Susan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State and 21060 19a. Informant's Name/Relationship (Type, Print) 7466 E. Furnance Branch Road Apt. 425, Glen Burnie Mary G. Peters (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Mem. Park 08-13-08 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2¥□No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Ś cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 《 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 SNo After this certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 0 GAVTRIA 32. Registrar Signature 31. Date filed (Month, Pay, Year) State alabor.

DHMH 17 Rev 1/2001

Registrar

1 _ State	O 1:6: 1 - 6 D - 11-	
Registrar	Certificate of Death	Reg. No. 2008 25/61
Physician  1. Decedent's Name (First, Middle, Last)  Physician	1eLL	2. Date of Death Month Day Year August 3, 2008 3/15pm
Medical Examiner  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	
Fundad 5. Social Security Number 6. Sex 7. Age (In yrs. Jast b)	rthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign
Director 330-94-7054 194M 2 F	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) (Country) (March 2) (1980) (March 2)
Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	n or Location	10d. Inside City Limits
NA Ctor Lord	Backmore	1) Yes 2□No
10a. State   10b. County   10c. City, Tow   10a. State   10b. County   10c. City, Tow   10a. State   10b. County   10c. City, Tow   10a. State   10b. County   10c. City, Tow   10c. Street and Number   10c. City, Tow   10c. City, Tow   10c. Street and Number   10c. City, Tow   10c	10f. Zip Code 2/2/6	10g. Citizen of What Country?
11. Marital Status  12. Was Decedent Ever in U.S.  Amned Forces?  12. Was Decedent Ever in U.S.  Amned Forces?  12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Dician, etc.) 14. Race - American Indian, Black, White, etc.
9	1 ☐Yes 2 No Specify:	Specify: BACK
Figure   F	a. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Industry
The state of the s	life. DO NOT ( retired)	ArA mark
T7. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surname)
and Mental and Mental	h Mailing Address (Street and Number or Ru	A   Se Paciety  ral Route Number, City or Town, State, Zip Code)
17. Father's Name (First, Middle, Last)  19a. Informant's Name/Belatjonship (Type. Print)  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	902 Bentalon	St. Balto, md, 21229
D D + 1 Commenter O Demonstration Commenter	of Disposition (Name of ery, crematory or other place)	Date 20c. Location - City or Town, State
A Donation 5 Other (Specify)  21. Signature of Funeral Service Licers	22. Name and Address of Facility	TO RUIST
21. Signeture of Funeral Service Licers	Nan 2405 W	all ace F.S. Balto ind. 2,229
23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart trailure. List only one cause on each ling.	not enter the mode of duing, such as cardiac	or respiratory arrest, Approximate Interval Between Onset and Death
Physician /Medical  Immediate Cause (Final disease or condition resulting in death)  A a. The second of the consequence of the	1 numonary embolis	m
Examiner Sequentially list conditions	monary embolism	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  5. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  5. Due to (or as a consequence or injury that initiated events resulting in death) Last  6. Due to (or as a consequence or injury that initiated events resulting in death) Last	of):	
that initiated events c	of):	
a page of the control		
NO THE PART OF THE		23d. Date of delivery
ABCOLDS.  The law requires that the death of that initiated events resulting in death) Last  The policy of the part of the par	h 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
w. requires that the defension at the defension of the de	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
require requir	-	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown
Sician The law requires the side of certificate has been signed to certificate has been signed to certificate has been signed by the law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requirements and law requirements the law requirements and law requirements are requirements.		24a. Was an autopsy autopsy findings available prior to completion of cause of death?
Contribution of the law and th	26. Place of Deat	1 □ Yes 2 No 1 □ Yes 2 MaNo th (Check only one)
1 Minpatient 2 ER/O	utpatient 3 □ DOA Other: 4 □ Nursing Ho Time of 28c. Injury at	ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
1 St Natural 5 Pending (Month, Day, Year)  1 St Natural 5 Pending (Month, Day, Year)  2 Accident investigation	Injury Work? M 1 □Yes 2 □No	
1   Yes 2   X   No	arm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Secretifying Physician: To the best of my knowledge of the control of the contr	e, death occurred at the time, date and place,	, and due to the cause(s) and manner as stated.
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier	29c. License number	rred at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
29b-Signature and title of certifier  Product House of Le	D45140	Wist, 3, 2008
30 Name and address of person who completed cause of death (Item 23a)		and P 1
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2000 West Bultimurs STY	tel, balamore, Muryland 21223
Registrar AUG 1 1 2008	barder	

08-05984 Lanny Noah Reese

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State of Maryland / Department of Health and Mental Hygiene	
State of Maryland / Department of Fleater and Montal Flygrens	

ny Noah Ree		I- For State	ate of	Maryla	ind / Dep Co			Health <i>Death</i>	and	Ment	al Hyg		Reg. No.	2	00	8	2576
Physici		Registrar  1. Decedent's Name (First, Midd	le,Last)									Date of Dea Month	Day	Year		Time of [ 1000 h	
Exami	ner	Lanny Noah Re									, A	August 5	, 2008			10001	irs
		4a. Facility Name (if not instituted 3750 Bel Pre Road	on, give str	reet and nu	mber)		4	b. City, Tov Silver S		ocation of	Death		1	County of Nontgome			1
		5. Social Security Number	6. Sex	<del></del>	7. Age (In yrs	. last birt	hday)	If Under		If Under	24Hrs. 8	B. Date of B		-		ace (Stat	e or Foreign
Funeral Director		171–38–5481		2 F	63		Yrs.	Months	_	Hours	Min.	Ju1y			Countr	<sup>(y)</sup> P.	1
		Usual Residence of Decedent	1 2+M	ZF_			113.										
any		10a. State 10b. County			10c. Ci	ty, Town	or Location	on									City Limits
	r	MD Mont	gome	ry	S	ilve:	r Sp	ring									2 X No
Aaryla 28a-f I at oi	Director	10e. Street and Number						10f. Zip C						izen of Wha			
death with the Maryland or items 23a or 28a-f show must be notified at once.		3750 Bel Pre							906					ted S			Diagram
is ≼	Funeral	11. Marital Status  1 X Never Married 2 N		<ol><li>Was Dec Armed Fo</li></ol>	cedent Ever in orces?	U.S.		Decedent es, specify				ify Yes or N can, etc.)	10-	14. Race - White,		indian,	ыаск,
or ite	Fun	••	- 1	Yes Yes, Give Yea	2 X No		1	Yes 2	X No	snecify:				Specify:	White	e	
72 hours after n "natural", c	ē	3 Widowed 4 Di  15. Decedent's Education (Sp.	or	· Dates:		) 16a.		's Usual O			kind of wor	k done	16b.	Kind of Bus			
2 hou "nati	Completed	Elementary/Secondary (0-12		College (1			during mo	st of worki	ng life. [	DO NOT	use retired	i)					
D36 thin 7 than edica	l du			2		1	Secu	rity							tial	Com	munity
5-0( led wi lygier other	S	17. Father's Name (First, Middle	e, Last)						18			irst, Middle					
21215-0036 suld be filed within 72 hours after death Mental Hygiene. marked other than "natural", or iter te event, the Medical Examiner must le	Be	Donald R. Ree			<u> </u>	1.0		A 1 leves	/6: .			J. Mc		city or Town	State 7	in Code)	
Should and Mis mis mis atic e	ြို	19a. Informant's Name/Relation			4									oa, F			
re, MD 213 s 1 and 2 should b f Health and Men If item 27 is mar er traumatic eve		Marcia R. Vall	LeTon	ga/ S	20	b. Place	of Dispos	ition (Name	of cem	etery,		Date	20c.	Location -	City or To	wn, State	e
of He		1 X Burial 2 Crematic	on 3 🔀	Removal fr	rom State S	crema	tory or oth	rer place) Ceme	tery	7	08/1	4/200	8 Sc	ottda	1e.	PΑ	
Baltimore, permit. Pages   ar Department of Her Important: If ite		4 Donation 5 Other 3		9		Asso	ciat	ion									
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important; If item 27 is mainjury or other traumatic ev		21. Signature of Fulleral Season	M		м	0095	6	Thiba	deau	1 Moi	rtuar	y Ser	vice ver	, P.A Sprin	e. M	D 20	910
hysician	_	23a, Part I. Enter the disease, of	or complica	ations that o	aused the de	ath. Do n	ot enter t	ne mode of	dying, s	such as c	ardiac or r	espiratory a	rrest, sh	ock, or hea	rt	Approxir	nate Interval
Vedical		failure. List only one caus  Immediate Cause (Final diseas	e on each	line.	ensive										- 4		Death
∠xamineı	1	or condition resulting in death)	_		a consequenc												
	L	Sequentially list conditions,	b	. ,						_					-		
	ine	if any, leading to immediate cause. Enter Underlying Caus	6	e to (or as	a consequend	e or):									1		
Ws.	Examiner	(Disease or injury that initiated events resulting in death) Last		e to (or as	a consequenc	ce of):											
executed an and al - transi			<b>−</b> d. <u>−</u>		23a,P1	T 27	ner	MF C	882	8/1	2/08	ጥጥ			<del></del>		
be be	edical	X UNPENDED		1000				me, c		0/1/			- 10	24 Date of	dalivani		
Box 68760, death certificate bhe attending physical for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant in	the	23c. If yes,	, outcome of p birth	regnancy		tal death	3	Ectopi	c pregnan	су	ľ	3d. Date of Month	Da	у	Year
x 68 h cert tendir use a	icia	past 12 months?		4 Preg	nant at time o	f death	5 O	ther (Spec	ify)								
Boy e death the att	ΙÉ	1 Yes 2 No 9 U		g Unkr						· · · · · · · · · · · · · · · · · · ·		220 Die	dtobacc	o use contri	bute to th	e cause	of death?
that the red by detach	by P	Part II. Other significant cond			to death but n	ot resultii	ng in the	underlying	cause g	iven in Pi	art I.			No 3			
S, P.C uires that n signed b	. –	Chronic alc	onor	use								1 24a. W				_	ngs available
cords, law requir has been s 2 should 1	Had											au	topsy rformed	p			of cause of
Division of Vital Records, and or Attending Physician: The law requirers after death.  By Director: After this certificate has been simpled in by the funeral director, page 2 should be led in by the funeral director, page 2 should a	Completed												s 2		<b>✓</b> Yes	:	2 No
/ital Rec ssician: The l nis certificate l director, page	Be	25. Was case referred to medi examiner?	_	anital:						of Death Other	(Check o	-	7.	dence 6	<b>2</b> 011		
Yhysic This call dire		1 ✔ Yes 2 No		spital: 1	Inpatient 2		Outpatien . Time of		<i>-</i>	ry at Worl		Home 5		njury occum		Scene	
Jof Jing Ph	=	27. Manner of Death  1 X Natural 5 Pe	ending	(Mon	e of Injury th, Day,Year)	200	, Time or	injury 12	_	res 2	_	E04. B030m		.,,,			
ivisior or Attendafter death Director:	j j		vestigation	380 Pla	ice of Injury -	At home	farm etre	et factory			- 1	28f. Locatio	n (Stree	t and Numb	er or Rura	al Route	Number, City
Division of pital or a pours after ceral Direction of filled in 1	Certification:	de	ould not be termined	(Specify		, tt nomo,	iam, out	, , , , , , , , , , , , , , , , , , , ,					n, State)				
lospita   hourn		4 Homicide	Physician	n: To the he	est of my know	wledge d	eath occu	irred at the	time, da	ate and p	lace, and	due to the c	ause(s)	and manner	r as stated	d.	
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys commletes filled in which filled the which filled the sea such be.	Medical	(Check only one) 2 Medical E	xaminer:	On the basis	s of examinati	on and/or	investiga	ation, in my	opinion	, death o	ccurred at	the time, da	ate and	place, and c	due to the	cause(s	)
To with	Mec	29b. Signature and title of cert		and manner	stated.			29c	. Licens	e number	г		29	d. Date sign	ed (Mont	th, Day, Y	'ear)
		(anal	1	-ll 1	Qa	v			O.C.I	M.E.			A	ugust 6, 2	2008		
$\sim$		30. Name and address of pers	on who co	mpleted ca	use of death	(Item 23a	)										
$\Diamond$					l Examine			Street, E	Baltim	ore, Mi	D 21201						
		31. Date filed (Month, Day, Yea	ar)	32. F	Registrar's Sig	gnature	Ca. N										
Regi	stra	AUG 1 1 2	2008	12 180	6/8/10 5/2 C			100									
	1000			OCM	E	<b>"</b> ^	DICIN	A I									

# **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar rust be nettined at once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Stat Registra

1	For State Registrar	State o	of Maryland	•	rtment of F tificate of		nd Mental Hy	giene, Reg. No.	0000	2576
	Decedent's Name (First, Midd	tle, Last)					2. Date of D	eath		3. Time of Death
ician dical	Amy Estelle R	idgway					Month 8/3	Day 3/200		9:25 p
	4a. Facility Name (If not institution	on, give street and nu	ımber)		4b. City, Town, o	r Location of			County of Death	
	Bethesda Heal	th & Rehab	)		Bethesd				ntgomery	7
, 	5. Social Security Number 578-26-5446	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bi Min. (Month, D 7 / 5 / 1	irth Pay, <i>Year)</i> L925	Cou	place (State or Forei ntry) 1and
	Usual Residence of Decedent  10a. State 10b. County	v	10c. City, To	own or Loc	cation					10d. Inside City Limit
										1⊠Yes 2□N
Director	MD P:	rince Geor	ge s	Ber	wyn Heigl   10f. Zip Code	its		10a Citi	zen of What Cou	ntry?
	5706 Quebec St	troot				0740			ed State	·
Funeral	11. Marital Status		edent Ever in U.S.	13. V			in? (Specify Yes or N		14. Race - Ameri	
by Fur	1 Never Married 2 Ma 3 X Widowed 4 Divorce	If Yes, Gi	2 X No ive	11	Yes, specify Cub ☐Yes 2XNo	an, Mexican, Specify:	Puerto Rican, etc.)		Black, White,	
	15. Decede	nt's Education	1		ent's Usual Occup			16b. Kir	nd of Business/In	
ple -	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (		(Give I life. E	kind of work done OO NOT use retire	during most ( d)	of working	Ĩ		,
Completed	12	College (	7-7-01-0+)		Homemal	ker			Own ho	me
BeC	17. Father's Name (First, Middle	, Last)				18. Mother	's Name (First, Middle	e, Maiden	Surname)	
10 E	Mortimer C. Jo	ohnstone				Lill	ian Yost			
	19a. Informant's Name/Relation	ship (Type. Print)	1	19b. Mailin	g Address (Street	and Number	or Rural Route Num	ber, City o	r Town, State, Zi	o Code)
	James Ridgway	/ son		9708	Bodmer A	Avenue	, Poolesvi	11e,	MD 208	37
	20a. Method of Disposition		come	e of Dispos	sition (Name of natory or other place	ce)	Date	20c. Lo	cation - City or To	own, State
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		State		n Cremato		8/8/2008	Alex	kandria,	VA
	21. Signature of Funeral Service	Licensee			Name and Addre	•		473	39 Balti	more Aver
1	23 Fart 1. Enter the disease, of	or complications that	raused the death. F						accsviii	Approximate Interval Between
	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any leading to immediate	Due to	(or as a consequence	ce of):	ACE	Den	RENTIA			Onset and Death
dical Exa	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to	(or as a consequent	ce of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	tcome of pregnancy birth 2 ☐ Fetal de nant at time of deatl nown	ath 3□	Ectopic pregnand Other (specify)	у		2	23d. Date of deliv	rery Day Year
à '	Part II. Other significant condit	ions contributing to d	eath but not resulting	g in the un	derlying cause giv	en in Part I.			40	the cause of death?
Completed							24a. Was	opsy	prior to co	opsy findings availal empletion of cause o
ပ္ပြဲ							1 □Yes	ormed? 2 <b>∑</b> 4No	death? 1 ☐ Yes	2 No
	25. Was case referred to medica examiner?				12		of Death (Check only			
1 1	1 Yes 2 Mo				t 3 □ DOA Oth	4,EFINUI:	sing Home 5 Res			fy)
sation:		igation	of Injury 28I th, Day, Year)	b. Time of Injury	28c. Injur Wor M 1 □	yat <br Yes 2 □ N	28d. Describe	how injury	y occurred	
Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	ningd   28e, Place	e of Injury - At home, ing, etc. <i>(Specify)</i>	, farm, stre	et, factory, office			(Střeet and wn, State)		al Route Number,
	29a. Certifier 1 Certifyi (Check only one) Certifyi	ng Physician: To the I Examiner: On the b and man	e best of my knowled basis of examination oner stated.	dge, death and/or inv	occurred at the ti restigation, in my o	me, date and pinion, deatl	I place, and due to the h occurred at the time	e cause(s) e, date and	and manner as place, and due t	stated. o the cause(s)
Σ.	29b. Signature and title of certific	er Bano	ciro		29c. Licens	e number	124		e signed (Month,	
	30. Name and address of persor	who completed caus	se of death (Item 23	a) (Type, F	Print)					
		1 - 16 1 -			11001 -	1	100 0000	. ^		
	Truong Bao, 97		Center D		201, Ro	ckvill	e, MD 2085	50		

State of Maryland / Department of Health and Mental Hygien [ ] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month AUGUST Yeer 9:26 pM 2003 Physician Harry B. Smith /Medical 4c. County of Death e street and number) Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**⊠**M 2□ F Yrs. 86 Aug. 11,1921 Maryland 219-18-7120 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show f Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f shov other traumstic event, the Modical Expressional to notified #1 1 ☐ Yes 2x No Director Catonsville MD Baltimore 10g, Citizen of What Country? 10e. Street and Number 21228 USA 1617 Park Grove Avenue Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: WWII Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Amarried White Specify 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Defense Department Executive Vice President 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Health and Mental Grace Knorr Edwin Bolden Smith ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 712 White Oaks Avenue; Catonsville, MD 21228 Son Sheldon C. Smith 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition , <u>=</u> 1 

Burial 2 □ Cremation 3 □ Removal from State 50 permit. Page Department of Important: If eny Injury or once. Loudon Park Cemetery 8/14/2008 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke 21. Signature of Funeral Service License Funeral Home of Catonsville, Inc. M01490 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CONGESTIVE HEART FAILURE HOUR **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 1☐ Yes 2 INO Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 300A 2 1 ☐ Yes 2 ☑ No After this Division of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 - Natural 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier D0051865 anyl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITML A6N23 CURTIS CMANLES 31. Date filed (Month, Day, Year) 62. Registrar's Signature State 2008

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 8 **Physician** 2008 Mae Elizabeth Schimp /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner tonsv MOLY timor lestown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F Yrs 22, 1909 Pennsylvania 98 Director 214-44-5470 Nov. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygeiner. Department of Health and Mental Hygeiner in Jatural?, or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 217 No Director MD Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 USA 223 Northway Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Henry Ruckert Edna Tudor ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Northway Road; Reisterstown, MD 21136 Edna Elizabeth Sloan-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 8/12/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service 1630 Edmondson Avenue; Catonsville 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 MIE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform the Hospital or Attending Physician: pin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 3 Name and address of person who completed cause of death (Item 23a) (Type, Print) hoice Lane Baltimore MD 21228 Maiden 31. Date filed (Month, Day, Registrar's Signature Year) State 2008 AUG 1

DHMH 17 Rev 1/2001

Registrar

	>c	arboroust Please Type or	District in Block in	adalibla ln	k Ensure	All Co	nies	Are Leait	ole.	
6027 .UNK		Please Type or State of	Maryland / Depa	artment of	Health and	Menta	l Hyg	iene		2000 057
ONIX		or State	Ce	rtificate of	Death			Reg.	No.	2008 257
Physician	_	distrar Decedent's Name (First, Middle,Last)					2.	Date of Death Month Date August 7, 20	ay Year	
'Examine		Mathew Austin Sc	arborough	T4	b. City, Town, or t	ocation of I	Death /	August 7, 20	4c. County of	f Death
	48	. Facility Name (if not institution, give so Sinai Hospital	treet and number)	T.	Baltimore		4			
Funeral	5.	Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	_	8. Date of Birth (	MM/DD/YYYY)	Birthplace (State or Foreign Country)
Director	- 1		1 2 F 16	Yrs.	Months Days	Hours	Min.	02/03/1	992	Maryland
		sual Residence of Decedent		Ť as l asati						10d. Inside City Limits
v any	10	Da. State 10b. County Baltim		y, Town or Location	on					1 Yes 2 X No
f shov	ᇗᆫ		101'6	1005011	10f. Zip Code			10g	. Citizen of Wh	at Country?
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	De. Street and Number  4 Aigburth Road			21286				U.S.	.A.
ith the 23a o notifi			12. Was Decedent Ever in	U.S. 13. Wa	s Decedent of His	panic Origin	n? (Spec	cify Yes or No-	14. Race White	- American Indian, Black,
items		X Never Married 2 Married	Armed Forces?  1 Yes 2 X No		es, specify Cuban		Puerto K	ican, etc.		
il", or	<b>—</b> I		f Yes, Give Year	1	Yes 2 X No		ind of wo	rk done	Specify:	White usiness/Industry
ours a		15. Decedent's Education (Specify only	y highest grade completed)  College (1-4 or 5+)	16a. Deceder during m	nt's Usual Occupations of working life	. DO NOT L	se retire			
36 in 72 h	e	Elementary/Secondary (0-12)	College (1-4-01-01)	St	tudent				Educ	cation
21215-0036 wild be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Completed	7. Father's Name (First, Middle, Last)				18.Mother's	Name (	First, Middle, Ma	aiden Surname	3)
215 215 3e file atal Hy ked o ent, th	æ	David Phillip				Gina	Mar	rie Ziel	inski per City or Toy	vn, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	P	9a. Informant's Name/Relationship (Ty						son. MD		
MD and 2 shows alth and 4 rand 27 is caumati	-  -	Norma Jean Marsch	1Ke/Grandillo Un	b. Place of Dispo	Aigburth sition (Name of ce	emetery,	100	Date	20c. Location	- City or Town, State
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		1 Burial 2 X Cremation 3	Removal from State	crematory or o	therplace) Serv. Cor	g.	08-1	2-2008	Tows	on, Maryland
ti. Pag tment rtant:		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licent								
Bal permi Depar Impo injur		Thailing 4	1110111	_   :	1050 York	k Roac	i, To	wson, M	laryland	ral Home, Inc. d 21204
ำysician	+	23a. Part I. Enter the disease, or compli	ications that caused the de	ath. Do not enter	the mode of dying	, such as ca	ardiac or	respiratory arre	st, shock, or he	eart Approximate Interva Between Onset and Death
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ords v requ s been should	Completed							autor perfo	osy ormed?	prior to completion of cause of death?
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		25. Was case referred to medical examiner?	Hospital:	a Taranti		Other <sub>4</sub>		ng Home 5	Residence 6	Other:
al Finant 1	ě		28a. Date of Injury	2 PR/Outpatie		njury at Wo		28d. Describe	how injury occ	curred
Vital F Physician: 1 r this certific al director, p	To Be C	1 Ves 2 No				_	<b>/</b> No	Subject sho	ot	
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be exemple. After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial-	on: To Be C	27. Manner of Death	Aug 7, 2008	0136 hrs	1_	Yes 2				
ision of Vital F Attending Physician: 1 r death. ector: After this certific by the funeral director, p	ication: To Be C	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigal	tion (Month, Day, Year)					28f. Location	(Street and Nu	mber or Rural Route Number, C
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 25,27,28a-f per me, 9882,08/08/08dhb State of Maryland / Department of Health and Mental Hygiene me, 9882,08/08/08dhb Reg. No. Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Jinclair can 405 Ul 2exs. /Medical 4a. Facility Name (If not institution, give street and number) Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saltimore neversely of Maryland Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 □ M 2 ☑ F 135-26-8628 Director June 22, 1931 New Jersey Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d, Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at Md. Baltimore Lutherville 1 ☐ Yes 2 ☒ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 8 Deep Run Rd. 21093 USA 23a Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 1 No 1 ☐ Yes 2 K☐
If Yes, Give
Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☒ No Specify: þ Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. It we Mo College (1-4or 5+) 5+ Elementary/Secondary (0-12) Securities Analyst/ VP Adams Express 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Eichenberg Mary Klebold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Deep Run Rd. Lutherville, Md. 21093 Mr. Hugh Sinclair/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Co. 7-24-08 Towson, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Salvice Licens 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician acetabular /Medical Due to (or as a consequence of): Examiner renom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be execute sician and burial-trant 410 101 Due to (or as a consequence of): Vital/Records, P.O. Box 68760, attending physician for use as the buria CERTIFICATION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 200 2 🗆 No 1 □Yes 1 ☐ Yes Physician; 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 1 XYes z Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA Division of this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attending Natural 5 | Pending Subject driver of golf cart that overturned and fell on her. 2 Accident investigation 04/25/08 **Unknowfi**<sup>M</sup> 1 ☐ Yes 2 📉 No 24 hours after deat Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **12801 Stone Hill Rd.** determined 4 Homicide Golf Course Phoenix, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060292 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltimore MD 22 5 Greene Manaher

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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2008

- found to the

32. Registrar's Şignature

Physic	cian	1. Decedent's Name (First, Midd	die, Last)						2. Date of Dea Month	Day	Year	3. Time of Death
/Med		Lindsay		Hanr	nah		cott	(B) (l)	07		2008 Inty of Death	00:22
Exami	iner	4a. Facility Name (If not institution Greater Balt			enter	4b. City, Town, o	or Location o	r Death			ltimo	
Europa	300	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 2		8. Date of Birt	th	9. Birth	place (State or Fore
Funera Director		N/A	1□ M <b>¾</b> □	F	Yrs.	Months Days	Hours	Min.	(Month, Da 07 2			MD
p z		Usual Residence of Decedent  10a. State 10b. Count	hv.	10c C	ity, Town or Lo	ncation						10d. Inside City Lim
Aaryla Febor	ō		timore		•	atonsvi	lle					1 □ Yes 2 🔀
Baltimore, Maryland 21215-UU3b permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other treumatic event, the Madical Examinar must be routilled at	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	untry?
h with	ai Di	1239 Alexand	ler Ave			21	228				U.S.F	١.
ems ar mu	ner	11. Marital Status	12. Was D	Decedent Ever in U	J.S. 13.	Was Decedent of I	Hispanic Orig	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14. F	Race - Amer Black, White	
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Z1Z15-UU36 d within 72 hours algiene. grene er then "natural", or the Wedical Exer-	ed b		ent's Education	or Dates.	16a. Dece	ident's Usual Occup	pation			16b. Kind o	f Business/I	ndustry
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A with your the tr.	Completed	N/A	N/	A		N/A					/A	
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should nd Men marke	2	Llewllyn B.  19a. Informant's Name/Relation		r.	10h Maii	ing Address (Street			lland	er City or To	wn State 7	in Code)
Mary nd 2 shoul lith and M 27 is mar r treumati		Lee Holland-	1 1 22 1		1239	Alexan	ider 2	Ave	Cato	nsvil	le, N	id 21228
ore, M os 1 and 2 of Health item 27 i	4.3	20a. Method of Disposition		20b.	Place of Dispo	osition (Name of	1991		Date	20c. Location	on - City or 1	Fown, State
Pages nent of H nnt: If its		1 X Burial 2 ☐ Cremation 1  Donation 5 ☐ Other		om State K		matory`or other pla emo <b>rial</b>		7/3	80/08	Wood	lawn	Md
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Day HELENA, SANDS AUGUST 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death CENTER WASHINGTON MEDICAL BURNIE HUNE HRUNDEL GHEN | State of Birth | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | Hou 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) <sup>Year)</sup> 1925 Dec. 220-14-8296 82 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 Yes 2 No Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. 217 Cloverhill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Acme Pad Company Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Blahut. Angeline Paramekis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 Cloverhill Road Pasadena, Maryland 21122 Louis C. Sands (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 08/09/08 Brooklyn, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Mins 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SHOCK SEPTIC 0445 Due to (or as a consequence of): INFECTION URINARY TRACT FAILURE RENAL 2CUTE

**Physician** /Medical Examiner

Department of Health are Important: If item 27 is any Injury or other trauonce.

**Physician** 

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e l'estical Examiner nunt be notified at

3altimore, Maryland 2121

HELEN

SANDS

/Medical

Director

Funeral

9

Be Completed

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or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician as the signed by the at the detached for page 2 certificate ours after death.

erai Director: After this certific filled in by the funeral director,

P.O. Box 68760,

Division of Vital Records.

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🗹 No 9 Unknown 9 Unknown Part II. Other significent conditions c ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ACI DOSIS METABOLIC 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perforn 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DO041284

29d. Date signed (Month, Day, Year)

08/06/08

State Registrar

To the Hospital within 24 hours a To the Funeral I Hospital

31. Date filed (Month, Day, Year) AUG I 2008

29b. Signature and title of certifier

RAYMUNDO

29a. Certifier

Medical



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 251 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Zin f ENTY A.SC DJAMM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner 5. Social Sequent Year If Under 24 Hrs. 8. 12 ing 8. Date of Birth (Month, Day, Year)
July 5, 19 rs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Funeral Days Hours Min 1**X** M 2 □ F Yrs. 1912 Massachusetts 96 Director 013 01 8316 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No notified Director Sykesville MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number filed within 72 hours after death with Hygiene. "natural", or items 23a or United States 21784 7200 3rd Avenue Apt A306 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3X Widowed 4 ☐ Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) American than Elementary/Secondary (0-12) College (1-4or 5+) Material Handling Engineer Scale & Conveyor 12 and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Schramm Emma Raim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is 3526 Lakeway Drive Ellicott City, MD 21042 Henry H. Schramm/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐Removal from State Hanover, MD Ardent Crematory 8-8-2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Collis Shem 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician en monia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the a 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 ☐ Probably 1 ☐ Yes 2 X No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy 2[ 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Hospital or Attending I 24 hours after death. Funeral Director; After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 \( \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \( \) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day,

AUG 1

2008

DHMH 17 Rev 1/2001

J			1 - For Amend Item State Registrar	State of lass 286,e,f	Maryland/De , per me, q	partment 82,08/1 ertificate	of Health of Death	and Me	ental Hygid Reg	ene J. No. 2008	25771
t	Physici	an	1. Decedent's Name (First, Middle,	Last)				T	2. Date of Death Month	Day Year	3. Time of Death
U	/Medic			dward	Teal			i	August	05 2008	3 12:42 A <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution,	-	*		wn, or Location			4c. County of Dear	
			5. Social Security Number		Age (In yrs. last birthd			7 MO	8. Date of Birth	N/	A thplace (State or Foreign
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			Usual Residence of Decedent		• /			1 .	01	1300	
	rylan show	_	10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
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0	ith th	Ö	10e. Street and Number			10f. Zip C		_	100	g. Citizen of What Co	
	s 23a	Funeral Director	3573 Barkley Sti		-15	0. W D I.	2075		" N. N.	US	
	item item	Š	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☑ Marrie</li></ul>	12. Was Decede Armed Force d 1 \( \overline{1} \)Yes 2[	nt Ever in U.S.	<ol> <li>Was Deceder If Yes, specify</li> </ol>	Cuban, Mexica	an, Puerto R	lican, etc.)	14. Race - Ame Black, White	
336	irs af	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1 □ Yes 2 □	No Specify	y:		Specify: V	Thite
Õ	2 hou	Completed	15. Decedent's	Education		cedent's Usual (			16	b. Kind of Business	Industry
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21	ed wi lygier lygier rer th		12	2	E	lectrica				Outdoor I	ighting
Baltimore, Marvland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If then 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, La Norman T	eal					First, Middle, Ma)	•	
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S	d2sh than t7 Isr traur		19a. Informant's Name/Relationshi Sallie E. Teal							City or Town, State, .	
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وَ	ages ent of it: If it		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from Sta	te 20b. Place of Discemetery, of	rematory or othe Cremator		Aug.	09	altimore,	
Ė	nit. Partme ortan injur		21. Signature of Funeral Service Li		THE ETO	22. Name and		200 lity			
B	Dep Imp any		1/1/2 /		1			St		Funeral H	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplications that caus	sed the death. Do not						Approximate Interval Between
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	/Medical	ш	resulting in death)		LTIPLE ( as a consequence of):	MGAN	PAIL	UNLE			
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	p ti	iner	Sequentially list conditions, if any, leading to him solute cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or e	as a consequence of):	^	1	111	- MER		
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OB B	death e atte	iciai	in the past 12 months?	4 □ Pregnan	it at time of death	3 ☐ Ectopic preç 5 ☐ Other <i>(spec</i>				Month Month	Day Year
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/ita	sician: The la certificate ha irector, page 3	Be (	25. Was case referred to medical examiner?				26. Plac	e of Death	(Check only one)		
of \	Physi this o	ည	1 Yes 2 No		atient 2 ER/Outpa			lursing Hom	e 5 🗆 Residen	ce 6 ☐ Other (Spe	cify)
'n	Jing F After funera	io iii	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		Day, Year) Injur	у	Injury at Work?		3d. Describe how		
isic	ttenc death stor: / the i	icat	2 Accident investiga 3 ☐ Suicide 6 ☐ Could no	JONE D.		-	1 ✓Yes 2	0.0	of 1 101		TRICAL INJULY
Division of Vital Records	lor A after Direc	ertification:	4 ☐ Homicide determin	ed building,	In ury - At home, farm, e.c. (Specify) Railroad (	rossino	nice	L	argo Roa	et and Number or Re State) Centra	⊥ Avenue &
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detache.	O	29a. Certifier 1 Certifying	Physician: To the be	st of my knowledge, de	eath occurred at	the time_date :	and place, a	nd due to the cau	ise(s) and manner a	s stated MD
	e Hoor 124 h e Fui	Medical	(Check only 2 Medical Ex	caminer: On the basis and manner	s of examination and/o	investigation, in	my opinion, de	eath occurre	d at the time, dat	e and place, and due	to the cause(s)
(1)	To th Within To th comp	Me	29b. Signature and title of certifier			29c. L	icense number		290	I. Date signed (Mont	h, Day, Year)
	Sh		D 4.14	re my		RES	-000			08/08/6	8
	(A)		30. Name and address of person w	ho completed cause o	f death (Item 23a) (Typ	e, Print)				· ·	
	(3)		ARPIT PATEL		ern Avenue	1 BALTIN	MORE,	MD 2	1224		
	Sta		31. Date filed (Month, Day, Year)	107	strar's Signature	and a					
	Registr	ar	AUG 11	2008	ias St. A.	28486					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Aug 16: 25 PM Ivan Albert Taylor, Jr. 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITAL SAINT AGNES BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Hours XXM 2 F Months Days Min. Director 215-78-3099 38 March 16, 1970 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c City Town or Location d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at 10d. Inside City Limits Director 1 ∏Yes 2X No MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1832 Palo Circle 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2√MNo If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes 2/CXNo Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic <u>Automobile</u> is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ivan Albert Taylor, Sr. Elaine E. Glaeser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine E. Taylor- mother 1832 Palo Circle, Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 Removal from State August 4 Donation 5 Dother (Specify) Meadowridge Mem. Pk. Elkridge, Maryland 9, 2008 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signafura of Funeral Service Ligensee M00053 4. Du MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** KENAL FAILURG disease or condition resulting in death) hours /Medical Due to (or as a consequence of): Examiner VARICEAL BLEEDING hours Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Exami SEVERE COAGULOPATHY burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical LIVER CIRRHOSIS monns IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

of Vital AYLOR

Division

31. Date filed (Month, Pay Year) 2008 Registrar

Mallina A



M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P22257

Aug

05

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8/5/2008 8:37 ам Jose Ignacio Hernandez Umana /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9108 Edmonston Road, #103 Greenbelt Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numbe Age (In yrs. last birthday **Funeral** 1 ☑ M 2 ☐ F Yrs Director 217-39-5092 81 7/1/1927 Salvador E1Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event, the Medical Examinar must he marting and injury or other traumatic event. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Directo Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9108 Edmonston Road, #103 20770 El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 1 XYes 2 No ģ Specify: Specify: 3 Widowed 4 □ Divorced El Salvadoran Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Own farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pedro Umana ဥ Juana Hernandez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bartolo Rivera / son 1941 North Edison Street, Arlington, VA 22207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ★Burial 2 Cremation 3 Removal from State 8/9/2008 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Washington, D.C. 21. Signature of Fundal Service Ligensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part. Ent. the discase, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, such as cardiac or respiratory arrest, since the mode of dying, since the mode of dying are cardiac or respiratory arrest, since the mode of dying are cardiac or respiratory arrest, since the mode of dying are cardiac or respiratory arrest, since the mode of dying are cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic colorectal cancer years /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2XNo Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation Injury 4 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide า 24 hours at 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check onl. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 one) and manner stated. 29b. Signature and tith 29c. License number 29d. Date signed (Month, Day, Year) 2 of cer cause of death (Item 23a) (Type, Print) 30. Name and addr Haidak, David J. 7525 Greenway Center Drive, #215, Greenbelt, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008

DHMH 17 Rev 1/2001

Registrar

AUG

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per me, 9884,10/09/08dhb 19a/fh State of Maryland / Department of Health and Mental Hygiene Amend Items 28b,f per me, 9882; 08/08/08/08/08 For State Registrar Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** SILAS 1740 PM 2008 JULY 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UMMS - SHOCK TRAUMA BALTIMORE CITY CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ F Director 234-04-6908 34 May 30 1974 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show the Medical Exactions: sust be notified at WV Hampshire Springfield 1 ☐ Yes 2 No Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 26763 Springfield Pike Road USA items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☐No If Yes, Give X Year or Dates: 1 Never Married 2 Married P Maryland 21215-0036 1 ☐Yes 2√☐No Specify Specify: white 3 Widowed 4 Divorced 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Revnolds Electric electrician 12 marked other Jis mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Max Eugene Wave Constance Ann Kittle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 & Department of Health au Important: If item 27 is any injury or other trau Tasha L. Lambert <del>(fincee)</del>Fiancee P.O. Box 150, Springfield, WV 26763 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 8-2-08 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Tagashight Herbert P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPTIC HOURE SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BOWEL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of):

Multiple Injuries Examiner be executed physician and s the burial-trans Due to (or as a consequence of): #22 Arial Records, P.O. Box 68760, Physician/Medical use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent oregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) the t Tyes 2 TNo detached 9 Unknown ۾ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ EXTREMETY ISCHEMIA 1 ☐ Yes 2/No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? PELVECTOMY 24a. Was an cate has page 2 s performed certificate 1 □Yes 1 ☐ Yes 2 ☐ No 2 (No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 panpatient 2 ER/Outpatient 3 DOA 1 No 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this After thi 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? Attending 5 Pending investigation 1 Natural MOTORCYCLE CRASH. death. 3:27 a <sup>M</sup> 1 ☐Yes 2 No 2 Accident
3 Suicide JULY 18, 2008 neral Director: , filled in by the f 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Rt. 28 near Rt. 956 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ö STRRET To the Hospital within 24 hours a Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stateGap, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certified Po 29d. Date signed (Month, Day, Year) 0 2008 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRAUMA UNIVERSITY MARYLAND - SHOCK CENTER 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 8 Registrar

State of Maryland / Department of Health and Mental Hygiene 25775 1 - For State Ragistrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death august 2008 **Physician** 7:208 M Madeline Helen Welsh /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Keswick Multi-Care Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 4/7/1918 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 218-05-7335 1 □ M 2 🕅 F Yrs. 90 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f show the Medical Everyle at most be notified at MD Worcester Berlin 1 ☐ Yes 2X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21811 USA 15 Gloucester Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itar 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: Specify: δ White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Kavanagh William Lambie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Welsh / Son 21 Kilsythe Road Arlington, MA 02476 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō parmit. Page Department of Important: If any injury or once. Garrison Forest Cem. 8/14/2008 Owings Mills, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one equise on each line. Approximate Interval Between Onset and Death Receivant Immediate Cause (Final disease or condition resulting in death) **Physician** phelinama 6 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner attending physician and for use as the burial-transit that the death certificata be exacuted Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant nad by the atten edetached for u 3 Ectopic pregnancy Day in the past 12 months 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signad by should be detact Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ otheroseleropie condishas cular advanced 3 Probably 1 TYes 4 Unknown Completed disease 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 24a. Was an certificate has autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: al or Attending P after death. I Director: After t d in by the funera 1 Matural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital or within 24 hours aft To the Funeral DI 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mac Gregor or D august 8, 2008 D13657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,700 W 40% STREET, BALTITIORE, MD 2121 MAESREGOR M- IP ABELLE 31. Date filed (Month, Day, Year) AUG 1 1 2008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 7, Day 2008 Year 10:20 John LLoyd Adams, Sr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore 811-D Briar Hill Place Essex 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/20/1928 Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Months Days Hours Min TSTM 2□ F Maryland 214-22-9785 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXXIo Baltimore Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. 811-D Briar Hill Place 12. Was Decedent Ever in U.S.
Armed Forces?

TYPY Ses 2 No 194
If Yes, Give
Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1945-1 ☐ Yes 2XXNo Specify. Specify: White 3 XXWidowed 4 □ Divorced 1948 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Recycling Owner/Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Merle Adams Della Boyles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811-D Briar Hill Place, Baltimore, Maryland 21221 Barbara Chambers (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 8/8/2008 Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory, Inc. 21. Signature of Eugenal Service Licensee 22. Name and Address of Facility Ski Funeral Home, P.A. Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final dise e or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐ Unknown 1 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy U 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Examiner sician and burial-trans the attending pl P.O. signed to Division of Vital Records, Jas page Physician; The certificate funeral director. this After t or Attending death. the within 24 hours after deatl To the Funeral Director; filled in by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

٥

Examiner

Physician/Medical

Completed by

Be

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be nother than a continuation.

**Physician** 

/Medical

altimore, Maryland 21215-0036

Medical Certification: To the Hospital completely 10 State

Registrar

63632

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIS

9600 32. Registrar's Signature

			1 - Stata Registrar		Maryland	/ Depa		t of H	ealth ar		ntal Hygi	ene	8 (8	25777	
	Physici		1. Decedent's Name (First, Middle Barbara Alice								Date of Death Month	Day 2008	Year	3. Time of Death 8:16 AM	_
	/Medic Examin		4a. Facility Name (If not institution Calvert Memori	-					Location of	Death	agas c	4c. County			_
	Funeral Director		5. Social Security Number 228–46–7614	6. Sex 7.	Age (In yrs. Ias	t birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, ar 28,	Year)	9. Birth	olace (State or Foreign ntry) ginia	,
	within 72 hours after death with the Maryland ene. then "naturet", or items 23s or 28s-1 ehow he Madical Examiner must be notified at	ector	Usual Residence of Decedent  10a, State	ert	10c. City, T	Town or Lo					10	g. Citizen of V		1 Yes 2 No	
	23e or	al Dir	3780 Solomons	Island Road	l		101. Zip		20639		10	USA		ntry ?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28s-f ehow amy nury or other traumatic event, the Madical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? XNo		Was Deced f Yes, spec 1 \( \text{Yes} \) 2		spanic Origin, Mexican, I	n? (Specify Puerto Rica	Yes or No- an, etc.)		k, White,	can Indian, etc. nite	
21215-0036	within 72 ho ane. then "natur ne Medical.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0·12) 1 2	's Education it grade completed)  College (1-4		life. L	kind of wor DO NOT us	rk done d se retired	urina most o	of working	1	6b. Kind of Bu		,	
land 2	uid be filed fental Hygir rked other lic event,	To Be Co	17. Father's Name (First, Middle, William Estel	Last)			secre	tary		,	rst, Middle, M	aiden Sumam	ity e)	groups	
, Maryland	and 2 shousalth and Mn 27 is man	_	19a. Informant's Name/Relationst Teresa Jamison/			6395	25th	Str	nd Number	or Rural Ro		City or Town,		Code)	
Baltimore,	Pages 1 tment of Hi tent: if iten fury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☒ Donation 5 ☐ Other (Sc	oecify)	000	e of Dispo netery, cren	sition (Nam natory or of	ne of ther place	<b>)</b>	Date	2	0c. Location -	City or To	own, State	
Bai	Depart Depart Import any in		21. Signature Funeral Service (On all I	11/18 46	rector	Be	ltimo	ore,	MD 2	1201		Baltimo	ore S	Street	
	Physician /Medical Examiner		23a. Part1. Enter the disease, of shock, a heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. COKO	as a consequer	ALT nce of):	enf				spiratory arre	st,		Approximate Interval Between Onset and Death	
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P.O. Box 68	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physiclen and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal de at time of deat	ath 3	Ectopic pre					23d. Dat Mor	e of delive	ery Day Year	
Ś	w requires that been signed b should be deta	ed by PI	Part II. Other significant condition  ANAMA		n but not resultii	ng in the ur	nderlying ca	ause give	n in Part I.	The state of the s	23e. Did toba			he cause of death? pably 4 □Unknown	
Vital Record	ysicien: The law re is certificate has be director, page 2 sho	Completed by									24a. Was an autopsy perform 1 ☐ Yes 2	ed?		opsy findings available impletion of cause of	
ō	ding After fune	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investig	9		VOutpatien  Bb. Time of Injury		8c. Injury Work	r: 4 □ Nursi	ing Home 28d.		ce 6 □Othe		(y)	_
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of	Injury - At home etc. (Specify)	e, farm, stre	eet, factory	, office			Location (Stre City or Town,		er or Rura	al Route Number,	_
	ne Hospi 24 hou ne Funei bletely fil	edical	29a. Certifier 1 Cartifying (Check only one) 2 Medical E	g <b>Physician</b> : To the be E <b>xaminer</b> : On the basi and manner	s of examination	edge, death n and/or inv	occurred a restigation,	at the tim in my op	e, date and pinion, death	place, and occurred a	due to the cau t the time, dat	ise(s) and ma e and place, a	nner as s and due to	tated. the cause(s)	
•	To the vithin 2 To the complet	×	29b. Signature and title of certifier	Lumb	NO	-		License		90	Į.	d. Date signed			
			30. Name and address of person of STANLAY Wish		of death (Item 23	3a) (Type,	Print)	CA	okn	40	00 2 - 402 0	T market	Ma	8 1-20639	)
	Sta Registr		31. Date filed (Month, Day, Year)	2 2008 32. 989	strar's Signatur		ast )	P		1.01	1 100		, ,	, , ,	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#1, perPHYS., G882, 8 12 708, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Wert **Physician** J Arvin Year 2638 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Johns Hopkins Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Director APRIL 17,1929 ٧A 228-22-6950 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD BALTIMORE 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1416 N. LINWOOD AVENUE 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 TYPYS 2 DNO If Yes, Give Year or Dates: 1 750-52 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ð Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5TH CRANE OPERATOR STEEL Pages 1 and 2 should be filed v nent of Health and Mental Hygie int: If item 27 Is marked other i 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev JOE T. ARVIN **EGGLESTON** ပ SADIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARRIE ARVIN/WIFE 1416 N. LINWOOD AVENUE, BALTO., MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) UNION CEMETERY EMETERY | 8/16/08 | KEYSVILLE, VA MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTIMORE, MD 21217 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure Physician 30 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Pericardial Effusion and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 2 No 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) R15-000 August 9 2008

Registrar
DHMH 17 Rev 1/2001

State

10+

4940 Eastern Ave. Baltemore, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line a-b, 25 perME, g884 10/3/08 TT
State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #11, perFH G882 8/19/08 TT
Certificate of Death

Reg. No. 200 Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 8,2008 **Physician** Terry L. Burkhart 1:15 a<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Ritchie Hospice Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 9, 1961 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 217-80-9379 1 □ M 2 😾 F Months Days Hours 47 Maryland Yrs **Director** Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Modical Exeminating the notified at 1 Yes 2 □ No Director Baltimore MD n/a 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 939 W. Lombard St. 21223 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🛣 No Specify. White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounts receivable Bookkeeping Maryland 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any light or other traumatic event once. 17. Father's Name (First, Middle, Last) George William Eberling, Jr. Mary Louise Beares 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou Karsner / sister 1509 Winfield Lane Gambrills, MD 21054 Baltimore, 20b. Place of Disposition (Name of Meadowridge Meadowridge Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/12/2008 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funera 2719 Hammonds Ferry Rd Lansdowne, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Chronic alcohol and drug abuse /Medical CEMPROATION APPROVED BY MEDICAL EXAMINES CO Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): Physician/Medical for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 I Inknown 9 Unknown icate has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No 1 □Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Nother (Specify) L fospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident within 24 hours after deat For the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 14383 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JMN Joseph Richey Hospice Baltimore MD Herold Stand; Cor 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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			1 _ State		artment of Healt				25700
			Registrar  1. Decedent's Name (First, Middle, Last)	Ce	rtificate of Dear			. No. 2008	
н	Physici	an		70 . 7.7			. Date of Death Month	Day Year	3. Time of Death
4.	/Medio		Mabel M.	Beall	I		ugust 9,		1:15 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or Location	ion of Death		4c. County of Death	
	Funeral		Futurecare Cherrywood  5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthday)	Reisters		. Date of Birth	Baltin	lore
	Funeral Director		213-24-8268 1□M 2☑F	80 Yrs.	Months Days Hou	ırs Min.	(Month, Day, Yo	ear) Couit	ntry)
			Usual Residence of Decedent	00		P	lar 28,	1920 Ma	ryland
	rylan how	_	10a. State 10b. County	10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Ba-fs	cto	MD Baltimore	Reis	sterstown				1 □Yes 2 🙀 No
	er 2	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cour	ntry?
	ath w	le	304 Cantata Court		21136			U.S.A.	
	should be filled within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, it is the dictal Ext. fill or must be recitived at	Funeral	11. Marital Status 12. Was Deceder Armed Forces	5?	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Speci	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
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21215-0036	houn	ed	3 ☐ Widowed 4 ☑ Divorced Year or Dates  15. Decedent's Education		dent's Usual Occupation		16	b. Kind of Business/Inc	hite
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<u>a</u>	uld bu Venta rrked	To E	John A. Diehl			Melva		Harris	
Maryland	and and is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailii	ng Address (Street and Nu	ımber or Rural I	Route Number, C	City or Town, State, Zip	Code)
≥,	es 1 and 2 : of Health a ltem 27 is		David W. Alban Son	2504	Flag Meadow	Court	Finksbu	rg, MD 21	048
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Exemination into the register of the angles of the solution of the register of the solution of t		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place)	Dat	e 20	c. Location - City or To	wn, State
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3a	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee	22	2. Name and Address of Fa	acility 118		terstown R	
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		S 111	23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not ent line.	er the mode of dying, such	h as cardiac or i	respiratory arrest	<b>t</b> ,	Approximate Interval Between
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<u>က်</u>	ires tha signed d be det	by	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Pa	art I.	23e. Did tobac	cco use contribute to the	ne cause of death?
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₹ <b>₹</b>	ilcian: Th certificate ector, pag	Be	25. Was case referred to medical examiner?			lace of Death (	Check only one)		
ot	Phys this	5		tient 2 ER/Outpatier				e 6 □Other (Specif	y)
U C	ding After funer	ion	1- Natural 5 Pending (Month, E	njury 28b. Time o Day, Year) Injury	Work?		d. Describe how	injury occurred	
S	death death stor: / the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 280 Place of II	nium. At home form et-	M 1 ☐ Yes 2		C. L		
Division of Vital	lor A after Direct	Certification:	4 Homicide determined building, of	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office	281	City or Town, S	et and Number or Rura State)	il Houte Number,
	spita neral fillec		29a. Certifier 1 Certifying Physician: To the bes	st of my knowledge, deat	h occurred at the time date	e and place an	d due to the cau	se(s) and manner as s	tated
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical	(Check only 2 Medical Examiner: On the basis and manner:	of examination and/or in	vestigation, in my opinion,	death occurred	at the time, date	e and place, and due to	the cause(s)
	To th withir To th соттр	Me	29b. Signature and title of certifier		29c. License numbe	oer	29d	. Date signed (Month,	Day, Year)
				-	173	7573		August 1	8005,1
	~		30. Name and address of person who completed cause of		Print)			3	
	リ		JOF Zabell MX		Mani St	Kei	refesta	- Mo .	21136
	Sta		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature				•	
	Registra	ar	AUG 1 2 2008	May Salande					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year CHANANYA 08 10 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UMMS BALTIMORE SHOCK TRAUMA BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Year) 02/01/1992 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 605-60-3763 16 Yrs Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 3409 OLYMPIA AVENUE 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify. If Yes, Give Year or Dates: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CATERER CATERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DOUGLAS BACKER ANGELA COHEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOUGLAS BACKER / FATHER 3409 OLYMPIA AVENUE, BALTIMORE, MD 20b. Place of Disposition (Name of AGUDATH Cranslette Office) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/10/2008 ROSEDALE, MD BALTIMORE 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatur of uneral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PENETRATING HEAD 48 HOURS disease or condition resulting in death) Due to (or as a consequence of): MOTOR VEHICL Squantially list or differentially list or di Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ZNo 2 2 No 1 Tyes 26. Place of Death (Check only one) 1/XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

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**Funeral** 

Director

show

?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar must be notified at

72 hours after

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than

permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr.

Maryland 21215-0036

Baltimore,

Examine Physician/Medical ģ

law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital

Physician:

Hospital or Attending

To th. within 2. To the Fu

burial-tran and physician the attending p led by the a signed I Completed peen has page 2 s certificate director Be မ Certification: After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

25. Was case referred to medical examiner? Yes 2 □ No

28a. Date of Injury (Month, Day Year) 28b. Time of

a No 1 ☐ Yes

28d. Describe how injury occurred

PASSENCER UNRESTRAINED MUC. IMTO A FENCE IN A Location (Street and Number or Rural Route Number, City or Town, State) 5 LADE AVENUE EN

29a. Certifier (Check only one)

cal

1 Natural

2/2XAccident

4 Homicide

3 ☐ Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined ROAD NEAR FARM LAND

08/2008

Seven Mile Lane Pikesville Marylas Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

☐ Could not be

18717-53905

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UMMS-SHOCK TRAUMA MD

NASRALLAH Year) 12 31. Date filed (Month

32. Aegistrar's Signature

State Registrar 0532 HOURS

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State		State of Ma	aryland		artment of t ertificate of			ntal Hy		2008	25782
			Registrar  1. Decedent's Name	e (First, Middle, La	st)			Tillicate of	Deal		Date of D	Reg. No. C	-000	3. Time of Death
	Physici /Medic		Donold Inc. Coole							Month	OG Day	OPear	0501 M	
and a	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location									4c. Co	ounty of Death	
	Funeral	7	5. Social Security No	Samar umber 6.5		05 DI	TA   ast birthday	Balt <sub>1</sub>	MO	er 24 Hrs. 8	Date of Bi	irth	N/A	place (State or Foreign
ı	Director		212-66-6	6122	XM 2□F	51	Yrs.	Months Days	Hours	Min.	Date of Bi (Month, D EB 3	1957	Lou	ntry) <b>land</b>
	and		Usual Residence of 10a. State	Decedent 10b. County		10c. City.	, Town or Lo	ocation						10d. Inside City Limits
	Maryl I sho	tor	MD	N/A			alti							1X Yes 2 □ No
	th the	Director	10e. Street and Nun	nber				10f. Zip Code				10g. Citize	n of What Cou	ntry?
	ath wi		4700 н	arford	,			2121					USA	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Pudical Examinat must be rediffed at	Funeral	11. Marital Status	ed 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ X		13.	Was Decedent of H If Yes, specify Cubi	lispanic ( an, Mexic	Origin? (Specif can, Puerto Ric	y Yes or N an, etc.)	0- 14	. Race - Ameri Black, White,	can Indian, etc.
5-0036	al", or	þ	3 ☐ Widowed 4 ☐ Divorced if Yes, Give Year or Dates:				1 □Yes 2 🖪 No Specify:					Si	pecify: W	hite
2-0	vithin 72 ho sne. <b>than "natu</b> l	Completed	(Speci	15. Decedent's Edify only highest gra	ducation ade completed)		16a. Dece	edent's Usual Occup e kind of work done DO NOT use retired	ation during m	ost of working		16b. Kind	of Business/In	dustry
12	within iene. <b>than</b>	dwo	Elementary/Secon	ndary (0-12)	College (1-4or 5			Mechani				Car	Deale	nahi u
פנ	be filed valued by the hygical Hygical	Be C	17. Father's Name (	First, Middle, Last,	)		Auto	nechan		ther's Name (F	irst, Middle			ranth
ylaı	should be filed w ind Mental Hygiel marked other ti umatic event, II	2	Raymond	G. Coo	ke, Sr.				W	lilma	Der	osset	t	
Maryland 2121	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Na			1		ng Address (Street						-
	es 1 and 2 should bof Health and Ment of Health and Ment item 27 is marked r other traumatic e		20a. Method of Disp	osition	, Jr bro	20b. Pla	ace of Disno	osition (Name of		Dundal			tion - City or To	
Ē	Pages tment of tant: If it		1 ☐ Burial 2 🖥 4 🗆 Donation	☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State			matory or other place		8/9/20	80	  Balt:	imore,	MD
Baltimore,	permit. Page Department of Important; If any Injury or once.		21. Signature of Fur	neral Service Licer	H H Will:		2	Name and Addre	ss of Fac	iety o	f Mar	vland.	Inc.	10.00
			23a. Part 1. Enter th	e disease, or com	plications that caused	the death.		299 Frede ter the mode of dyir					MD 2	1228 Approximate Interval Between
Š	Physician		Immediate Cause (I disease or condition	Final	one cause on each lin	ie.	VD						4	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):											
	Lxammer	Sequentially list conditions, if any, leading to immediate b.    b.    C S D on H D  Due to (or as a consequence of):												
١.	uted d ansit	if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								1				
2	be executed ician and burial-transit													
\$09/89	rificate be executed g physician and as the burial-transit	edical			.d									
×	leath certiff attending for use as		IF FEMALE: 23b. Was decedent	prognant	23c. If yes, outcome of	of pregnan	су					220	d. Date of deliv	
	death le atten	Physician/M	in the past 12 r	months?	1 Live birth 1			☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	У			230	Month Month	Day Year
л. Э	at the d by th etache	Phys	9 Unknown		9 Unknown					- 3				
ds,	es the igne	ģ	Fact II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
Hecords	w requ	Completed						-		_ }	24a. Was			opsy findings available
He	ician: The law certificate has ector, page 2 a	шо			·						auto perfe	psy ormed?	prior to co death?	mpletion of cause of
	cian: ertifica ector, p	Be	25. Was case referre	ed to medical					26. Pla	ce of Death (C	1 □ Yes Check only	2 ☑No one)	1 🗆 Yes	2⊠No
5	Physician: rthis certific ral director, I	္	1  Yes 2 ✓					nt 3 DOA Oth	4 🗆				Other (Special	(y)
5	ding th. After funer	i i	27. Manner of Death  1. Natural 5 Pending (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  2 Accident investigation  M 1 Yes 2 No											
VISION	r Attender deather deather rector:	Certification:	3 Suicide 6 Could not be 28e Place of Injury - At home farm street factory office 28f Location (Street and Number of Rural Pouts Number								al Route Number,			
2	ital or irs afte ral Dir lled in	Ser	4 Homicide determined building, etc. (Specify)											
	To the Hospital or Attending F within 24 hours after death.  To the Funeral Director; After completely filled in by the funeral Director.	Medical	29a. Certifier (Check only one)	1 ☑ Certifying Ph 2 ☐ Medical Exan	ysician: To the best on niner: On the basis of and manner stat	examination	ledge, deat on and/or in	h occurred at the tir estigation, in my o	me, date pinion, d	and place, and eath occurred	I due to the at the time	cause(s) ar date and pl	nd manner as s ace, and due to	stated. the cause(s)
	Vithi Vomp	ž	29b. Signature and t	itle of certifier	-			29c. License	_			1	signed (Month,	
)			Bur	W 1)			-	172	77	てナ		8 /	810,	8
	1		30. Name and addre	ss of person who	completed cause of de	eath (Item 2	23a) (Type,	Print) Am	2 N	127	100	od.	MD	21234
	Stat	е	31. Date filed (Month	Day, Year)	32 Registra	- 1	e de	selle!	1					
	Registra	ır	A	CO T 8 6	The state of the state of	and the	18 Mg 35							

08-05865 Virginia Corbin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

rginia Corbin	1- For State	epartment of Health and Mental H De <i>rtificate of Death</i>	yglene 2008 2578						
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		Date of Death     Time of Death						
le" al Examiner	Virginia Anna Corbin	The same of the sa	July 31, 2008 1206 hrs						
	Facility Name (if not institution, give street and number)     St. Agnes Hospital	4b. City, Town, or Location of Death Baltimore	N/A						
Funeral 📉	5. Social Security Number 6. Sex 7. Age (In y	vrs. last birthday) If Under 1 Year If Under 24Hrs	Foreign						
Director	213-28-8547   1 M 2XF   74 Yrs.   Months   Days   Hours   Min.   Jul. 10, 1934   Country)   MD								
any	Usual Residence of Decedent  10a. State 10b. County 10c. (	City, Town or Location	10d. Inside City Limits						
<b>*</b>	MD N/A	Baltimore	1 X Yes 2 No						
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
th the Mar 23a or 28 notified a	3330 Wilkens Ave.	in U.S. 13. Was Decedent of Hispanic Origin? (S	United States  Decify Yes or No- 14. Race - American Indian, Black,						
leath with ritems 22 usst be no	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever Armed Forces? 1 Yes 2 X	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.						
s after do	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify: White						
hours 'natur Exam	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12) College (1-4 or 5+)	d) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	work done 16b. Kind of Business/Industry ired)						
5-0036 led within 72 hours afterlygiene. other than "natural". the Medical Examiner Completed by	8	Homemaker	Own Home						
	17. Father's Name (First, Middle, Last) Otto Mauer		e (First, Middle, Maiden Surname)						
- 0	19a. Informant's Name/Relationship (Type, Print )		11ian F. Tolson Rural Route Number, City or Town, State, Zip Code)						
MD 21 nd 2 should I alth and Mer m 27 is may aumatic ev	Peggy Corbin - daughter	3589 Benzinger Rd., I	Baltimore, MD 21229						
	20a. Method of Disposition  Burial 2 Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State						
Baltimore, permit, Pages I an Department of He Important: If ite	4 Donation is Other Specify:	Atlantic Crematory 8-	-10-2008 Glen Burnie, MD						
Baltimo permit, Page Department o Important: injury or oth	21. Shipproce of Fulleral Service Licensee	11328 Sulphur Sprin	prose Funeral Home, Inc.						
Physician	23a. Part I. Enter the disease, or complications that caused the c	death. Do not enter the mode of dying, such as cardiac sclerotic cardiovascular	or respiratory arrest, shock, or heart disease in Approximate Interval Between Onset and						
Medical	Immediate Cause (Final disease a. association with complications of chronic alcohol abuse								
	or condition resulting in death)  Due to (or as a consequent by the condition resulting in death)	nce ot):							
ner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause	nce of):							
red nisit	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of the co	nce of):							
Trans		27,perME, g884 10/9/08 TT							
the death certificate be executed by the attending physician and ched for use as the burial - transit	X UNPENDED AMENDED 23d, 2		23d. Date of delivery						
30x 6876(  Jeath certificate e attending phy for use as the b	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time	2 Fetal death 3 Ectopic preg	nancy Month Day Year						
30X death c le atten I for us	1 Yes 2 No 9 Unknown	of death 5 Other (Specify)							
P.O. B s that the d gned by the c detached by Dhy		t not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vunknown						
S, P.C puires that puires that an signed and be determed by			24a. Was an 24b. Were autopsy findings available						
Records, The law requires finate has been sign, page 2 should be			autopsy prior to completion of cause of death?						
Vital Rec ysician: The l his certificate I director, page		26.Place of Death (Chec	1 V Yes 2 No 1 V Yes 2 No						
Vital hysician this cert	examiner?  Hospital: 1 V Inpatient	2 ER/Outpatient 3 DOA Other4 Nur	sing Home 5 Residence 6 Other:						
of ing Phy	27 Manner of Death 28a Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred						
Sior Attend death. ector: by the	Natural 5 Pending 2 Accident Investigation	- At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City						
Division o spital or Attending hours after death. neral Director: After filled in by the fune	3 Suicide 6 Could not be determined determined (Specify)								
		nowledge, death occurred at the time, date and place, a ation and/or investigation, in my opinion, death occurre	nd due to the cause(s) and manner as stated.						
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner: On the basis of examina and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
	Downt Know Hall no	O.C.M.E.	August 1, 2008						
1	30. Nante and address of person who completed cause of death	h (Item 23a)							
$\Psi$	Pamela E. Southall, MD Assistant Medical		, MD 21201						
Stat Registra	ANTITY OF ANTITY OF A STATE OF A	Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3, 2008 **Physician** Marcellus Cobb 3:20 PM M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Hamilton Baltimore 8. Date of Birth (Month, Day, Year) Mar 31, 1936 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 11X M 2 ☐ F 216-30-0469 72 North Carolina Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Director MD 1√2Yes 2□No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6040 Harford Road 21214 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status unk Black, White, etc. unk 1 Yes 2 If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify \$ Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genesis Hamilton 6040 Harford Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other(Specify) in state 21. Signal are of Funeral Servi State Anatomy Board 655 W. Baltimore Street Wade Director Baltimore, MD 21201 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) **Physician** worker /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of) MIN Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specity) 1 Yes 2 No 은 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2

State Registrar 29b. Signature and title of certifier

A 31. Date filed (Month, Day, Year)

SHVA113

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

HOYS HM, MD

\$21 N. BUTAN ST Printe 308

MU

29c. License number

29d. Date signed (Month, Day, Year)

BALTIMORE MD 21201

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 2008 Francisco D. Carmona 6.55 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Square Hospita Baltimore ROSE da le If Under 1 Year | If Under 24 Hrs. ranklin Social Security Number 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) 6-13-1930 Birthplace (State or Foreign Country) **Funeral** ₩ M 2□ F Months Days Hours Min 216-43-7942 78 Director Philippines Usual Residence of Decedent death with the Maryland 10a. State 10b. County 28a-f show 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Balto. Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Compass Rd. Apt. 131 21220 Funeral USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 24 ☐ No þ Specify Asian Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, Item once. Accounting Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vicente Carmona Salud Dimbla ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Arciaga DTR. 47<u>22 Stellabrooke Lane</u> Rosedale, Md.21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview 8-12-2008 Balto. 21. Signature of Jun Service Lie 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner neumon Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duly to for as a consequence of Due to (or as a consequence of): Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à funeral director, page 2 should Completed 1 ✓ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the I within 2 To the P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) seller D39963 D8 08 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Franklin Square Drive Baltimore, mo 21237 Stuart c+ W://es Day, Year) AUG 1 2 2008 31. Date filed (Month. State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Mary Margaret Clark 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner tark Health & Nehab. 4ir 8. Date of Birth (Month, Day, Year) Sept 5, 1917 If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Country) Maryland Days Months Hours Min. 1□ M 2(XF 212-01-5811 90 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes ZHNo Funeral Director Harford Forest Hill MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US 21050 2806 Van Horn Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Iter 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Pagliughi Maria Zanalotti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Petr (Daughter) 2806 Van Horn Road, Forest Hill, MD other Department of Heat Important: If Item 2 any injury or other once. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/09/2008 4 □ Donation 5 □ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home, Inc. of Funeral Service 9705 BelAir Road, Perry Hall, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardio pulmonary disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 20 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 1 ☐ Yes 1 Inpatient 3□ DOA 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٦ this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation Injury Natural М 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours a

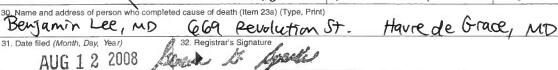
To the Funeral I

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifie



29c. License number

T 006398

29d. Date signed (Month, Day, Year)

2008

		1 State Registrar		artment of Health and rtificate of Death	Reg	ene 2008	3 25787					
Physic /Med												
Exam		4a. Facility Name (If not institution, give street and number) Franklin Woods Nursing Center		4b. City, Town, or Location of Dea	ath	4c. County of Deat						
Funera Directo		218-28-0787 1□ M 2 <b>K</b> JF	(In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under 24 Hi Months Days Hours Mi		9. Birti	hplace (State or Foreign yland					
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A	10c. City, Town or Lo	cation altimore		-	10d. Inside City Limits 1 X Yes 2 □ No					
with the	Funeral Director	10e. Street and Number 2205 Pelham Avenue		10f. Zip Code 21213	10	g. Citizen of What Co. U.S.A.	untry?					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, ite Modical Evantical must be notified at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married 1 □ Yes 2 □ Not 1 □ Yes 2 □ Not 1 □ Yes 2 □ Not 1 □ Yes 2 □ Not 1 □ Yes 2 □ Yes 2 □ Year or Dates:	0	Mas Decedent of Hispanic Origin? fYes, specify Cuban, Mexican, Pue t □Yes 2 ⋈ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify:						
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental hygiene. 71 is marked other than "natural", or traumatic event, the Modical Example	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4or 5+	16a. Deced (Give life. L Adminis	dent's Usual Occupation kind of work done during most of w DO NOT use retired) strative Aid	orking	institute  Notre Dame	ndustry. 3 Of					
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, Mary and 2 shou alth and N 27 Is man	-	19a. Informant's Name/Relationship (Type. Print)  Mary R. Craig - Daughter	19b. Mailin <b>417 M</b> i	ng Address (Street and Number or a Lindock Avenue Balti	Rural Route Number, More, Parylar	Dity or Town, State, 2 Cl 21212	?ip Code)					
Baltimore,  bermit. Pages 1 ar  Department of Hea  Important: If Item 3  any Injury or other		20a. Method of Disposition 1 I  Burial 2  □ Cremation 3  □ Removal from State 4  □ Donation 5  □ Other (Specify)		sition (Name of natory or other place) art of Jesus 08/		oc. Location - City or undalk, Mary						
Balt permit. Depart Import		21. Signature of Funeral Service Licensee	Lec	Name and Address of Facility Onard J. Ruck, Inc.	5305 Harfo Baltimore	ord Road , Maryland 2°	1214					
Physiciar		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
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DIVI  To the Hospital or Avery within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To th within To th	Me	29b. Signature and Affice of certifier		29c. License number		d. Date signed (Month						
		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, F	D534	62	8/11/0	8					
S	ate	31. Date filed (Month, Day, Year) AUG 1 2 2008	's Signature	Kubod Road	GlenB	imie, m.	D 21061					
Regis	rar	AUG 1 2 2008	M. Son	refer								

			for State Registrar	State of Mary	land / De	partment d <i>Certificate</i> (	of Health of Death	and Ma h		eg. No. 200	8 25788	
ı	Dharini		Decedent's Name (First, Middle, Last)		-				2. Date of Deat Month		3. Time of Death	
	Physici /Medic		Maria	Castillo_		Canto			August	3, 2008	3:00 p <sup>M</sup>	
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	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits	
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	eath w	Funeral	2658 Lehman Avenue	. Was Decedent Ever	21223 Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica			cify Ves or No-	USA	merican Indian,		
သူ	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Modical Eventiner matter refined at	by Fun	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0.0.	If Yes, specify 1 ☐ Yes 2 🛣			Rican, etc.)	Black, W	hite, etc.	
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nor	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei			sposition (Name of crematory or other Park Ceme				•	Maryland	
baitimor	mit. P partme portan / Injur		21. Signature of Funeral Service Licensee							k Funeral		
מ	B a la		3620 Wilkens Ave., Baltimore, MD 2122									
	Physician		23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Hypertension									
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ν, Τ	s that gned b	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tol						obacco use contribute to the cause of death?			
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ပ္သ	e law has b	mple							24a. Was a autops perforr	y prior	autopsy findings available to completion of cause of	
<u> </u>	an; Th tificate or, pag		25. Was case referred to medical				OC Dia	as of Death	1 ☐ Yes 2	2 XNo 1 1	res 2□No	
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vision of	Ing Pt	L:uo	27. Manner of Death 1	28a. Date of Injury (Month, Day, Yea	ar) 28b. Tim	ry	Injury at Work?		8d. Describe ho	ow injury occurred		
20	ttend death. ctor: / the fi	ertification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Injury -	At home farm		1 ☐ Yes 2 ☐		28f. Location (Street and Number or Rural Route Number,			
2	al or A s after Il Direct	Sertif	4 ☐ Homicide determined	- At home, farm, street, factory, office 28f. Locatio Specify) 28f. Locatio City or					Town, State)			
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my er: On the basis of exa and manner stated.	y knowledge, d mination and/o	eath occurred at to r investigation, in	he time, date my opinion, de	and place, a eath occurre	and due to the ced at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier			29c. Li	cense number	r	2	29d. Date signed (Month, Day, Year)		
	(		D0062966						A	August 5, 2008		
	4		30. Name and address of person who com Peter S. Greene, I				altimo:	re. Mr	21201			
	Sta		31. Date filed (Month, Day, Year) ALIC 1 2 2008	32 Registrar's S	Signature	and a		,				
	Registr	or .	A 1111 1 7 /11110	B 10 255 A	35 Ast	The state of the s						

	1	For State Registrar	State o	of Marylan	d / Depa <i>Cel</i>	artment of I rtificate of	Health a <i>Death</i>	and Mental H	lygiene Reg. No		3 25789
Physiciar /Medica Examine		1. Decedent's Name (First, Middle  Dolores Dough la. Facility Name (If not institution	nerty	mber)		4b. City, Town, o	or Location o	2. Date of Month  Augus of Death	Da st 2,	2008 County of Dea	
Funeral Director		Gilchrist Hos 5. Social Security Number 214-12-1534	Spice 6. Sex 1□M 2∏F	7. Age (In yrs. 86	last birthday) Yrs.	Towsc  If Under 1 Year  Months Days	If Under 2		Dav. Year)	C	ore httplace (State or Foreign puntry) ryland
or 28a-f show	ŀ	Jsual Residence of Decedent  10a. State 10b. County  MD Balt	imore	10c. Cit	y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 No
72 hours after death w 72 hours after death w "natural", or items 23a dical Exprisive rount	Completed by Fulleral	10e. Street and Number  615 Chestnut A  11. Marital Status 1 Never Married 2 Marital Status 1	12. Was Dec Armed Fe 1   Yes   1   Yes   Year or Dec Armed Fe   1   Yes   Year or Dec Armed Fe   Yes   2 XNo ive Pates:	16a. Dece (Give life.	Was Decedent of If Yes, specify Cut 1 □ Yes 2 ▼ No dent's Usual Occu kind of work done DO NOT use retire	Specify:  pation during most ed)  e dire	•	No- 16b. K	ind of Business	erican Indian, te, etc. <b>hite</b> /Industry	
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permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra	3-	Mary Van Fossa  20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 XI Donation 5 □ Othe) (S	3 ☐ Removal from	20b. F		esition (Name of natory or other pla		ad Trappe,		21673 ocation - City or	Town, State
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The law requires that has been signed age 2 should be down	e combiered by	Part II. Other significant conditions  History of  Coronary  PROGRESS  25. Was case referred to medical	Breas antery	eath but not resu T Can dusea Deman	ulting in the un	postw	T	1 [ 24a. W	Yes 2 as an attopsy arformed?	No 3 P	o the cause of death?  Probably TUnknown  utopsy findings available completion of cause of  s 2 \( \sum No
erthis eral di	2	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin investig 3 Suicide 6 Could 4 Homicide	g 28a. Date (Mon	nth, Day, Year)	28b. Time of Injury	28c. Inju	her: 4 🗆 Nu	rsing Home 5 R 28d. Describ	esidence be how inju	nd Number or R	ecify) TOSPICE
-=		29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the Examiner: On the b	e best of my kno pasis of examina	wledge, deat	h occurred at the t	time, date an	d place, and due to the tind	the cause(s	and manner a	as stated. e to the cause(s)
To the Hosp within 24 hos To the Fune completely fi		29b. Signature and title of certifie	e RF	aner stated.	lle 123a) (Type	Da	se number	43	29d. Da	ite signed (Moni	th, Day, Year)
State Registrar	Į	Kerdall R. Fa B1. Date filed (Month, Day, Year) AUG 1	ulknow	~ / ~	55 W	. Tousa	town	-Blud/	Bal	timore	40618 (M)

DHMH 17 Rev 1/2001

**ORIGINAL** 

08-06094 Steven Duane Ed	skor	Please Type or Print in B				ible.	
Steven Duane Lt		I- For State	•	nt of Health and Mental H te of Death		200	10 2570
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		e or beaut	Reg 2. Date of Death	. 140.	3. Time of Death
Medical Examir			Eckenrode			Day Year	1654 hrs
ť		4a. Facility Name (if not institution, give street and numbe	r)	4b. City, Town, or Location of Death		4c. County of Death	
		Eastbound I70		Hancock		Washington	
Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthd			(MM/DD/YYYY) 9. Birt	
Director		214-56-0998 1 <sub>X</sub> M 2 F	58	Yrs. Months Days Hours Min	02/04		untry) MD
<b>A</b>	-	Usual Residence of Decedent					40.1
w any		10a. State 10b. County	10c. City, Town or				10d. Inside City Limits  1 Yes 2 No
yland Preserve	ġ	Maryland Anne Arundel  10e. Street and Number		Pasadena		- Citimen of What Cour	
Mar or 28a	Director	17 Kellington Drive		10f. Zip Code 21122	10	g. Citizen of What Cour USA	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Deceder	at Ever in IIS 11	3. Was Decedent of Hispanic Origin? ( Sp	pacify Vas or No-		can Indian, Black,
eath w items	Funeral	1 Never Married 2 X Married Armed Forces	3?	If Yes, specify Cuban, Mexican, Puerto		White, etc.	can moran, black,
fter de		3 Widowed 4 Divorced If Yes, Give Year	2 No	1 Yes 2 X No specify:		Specify: M	nite
ours a	d b	15. Decedent's Education (Specify only highest grade co	ompleted) 16a. De	ecedent's Usual Occupation (Give kind of		16b. Kind of Business/l	
72 hc	leted	Elementary/Secondary (0-12) College (1-4 or	r 5+)	ring most of working life. DO NOT use reti	red)		
5-0036 filed within 72 Hygiene.	Comple	12		Welder		Coast G	uard
15-C	ပ္မ	17. Father's Name (First, Middle, Last)		18.Mother's Name	(First, Middle, M	aiden Sumame)	
2121 wild be fi Mental J marked c event,	a a	James R. Eckenrode		Winifre		orman	
MD 2 d 2 shoul lth and M n 27 is m	유	19a. Informant's Name/Relationship (Type, Print)  Karen D. Eckenrode (spo	- 4	Mailing Address (Street and Number or I			
and 2 and 2 cealth tem 2 traum	4	Karen D. Eckenrode (spo		7 Kellington Drive, Disposition (Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hea Important: If ite		1 X Bunal 2 Cremation 3 Removal from S	nate .	y or other place) Aug			
it. Partiment truent	-	4 Donation 5 Other Specify: 21. Sig . ure of Føneral S€rvice Lic : s e	Maryla	nd Veterans Cem 20	008		e, Maryland
Bal permi Depa Impo injur	- 1	Mustall Alle	1	3111 mountain Ro			Home, P.A.
Physician	-	23a. Part I. Enter the disease, or implications that thuse					Approximate Interval
Medical		Immediate Cause (Final disease a Multiple Injurie					Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injurie Due to (or as a con					
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Box 68760, e death certificate be the attending physicied for use as the buri		72h Mas decodest program in the	ome of pregnancy			23d. Date of deliver	
certif	Sian	past 12 months?	at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	ancy	Month I	Day Year
Box e death c the atten	ysi	1 Yes 2 No 9 Unknown 9 Unknown	3	Other (Specify)			
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Division of Vital Records, tal or Attending Physician: The law requir is after death.  at Director: After this certificate has been siled in by the funeral director, page 2 should the	Completed				24a. Was a autops		topsy findings available completion of cause of
ecc he lav ate ha	E				perform 1 <b>V</b> Yes 2		es 2 No
of Vital Recoing Physician: The law After this certificate has Tuneral director, page 2 sl	Bec	25. Was case referred to medical		26.Place of Death (Check	only one)		
Vit;	ol	examiner?  1 Yes 2 No Hospital: 1 Inpat	tient 2 ER/Outp	patient 3 DOA Other Nursin	ng Home 5 F	Residence 6 🗸 Othe	r: Scene
ding Ph	Ë	27. Manner of Death  1 Natural 5 Pending Aug 9, 2008	jury 28b. Tir Year) 1010	me of Injury 28c. Injury at Work?		ow injury occurred driver collided v	with a deer
ision Attend r death. rector: by the f	atio	1 Natural 5 Pending Aug 9, 2008 2 Accident Investigation	1646 h	1 Yes 2 ✔ No	and guardra		war a door
IVIS lor A after of din by	Certification:	Suicide Could not be		n, street, factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Ruate) , Hancock , MD	ral Route Number, City
Division  Hospital or Attence 24 hours after death Functal Director: tely filled in by the	Çer	4 Homicide determined (Specify) In 29a. Certifier	terstate/Expres	5	Eastbound I70	, Hancock , MD	
동절들송		(Check only one)  Certifying Physician: To the best of expenses of	my knowledge, death	n occurred at the time, date and place, and restigation, in my opinion, death occurred	I due to the cause at the time, date a	e(s) and manner as stated to the state of th	ed. ne cause(s)
To the within 2 To the complet	Medical	29b. Signature and title of certifier	1.	29c. License number	2, 510 time, date o	29d. Date signed (Mo	
		Signature and trie of certifier		O.C.M.E.		August 10, 2008	
7		Wryonte The Snill		O.O.IVI.E.		, lugust 10, 2000	
15+1		<ol> <li>Name and address of person who completed cause of Margarita Korell MD. Assistant Medica</li> </ol>		11 Penn Street, Baltimore, MD	21201		
10 1	ate	31. Date filed (Month, Day, Year) 32 Registr					
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			1 - State Registrar	State of Maryla		partment of l Certificate of		, ,	jiene <sub>leg. No.</sub> 2 ()	I N R	25701
		Ā	Registrar     Decedent's Name (First, Middle, Last	st)		-crimeate or	Dealit	2. Date of Dea		00	3. Time of Death
	Physicia /Medic		Christopher	Michael	Ero			Month () 8	O 8 2	Year	9.10PM
è	Examin	er	4a. Facility Name (If not institution, give Mercy Medical			4b. City, Town, Balty	or Location of Death	1	4c. County	of Death	a Cita
, es	Funeral		5. Social Security Number 6. S	ex 7. Age (In yr	rs. last birtho		If Under 24 Hrs.	8. Date of Birth	1		place (State or Foreign
	Director		N/A Usual Residence of Decedent	<b>⅓</b> M 2□ F	Yrs	s.   World   Bays	Tiodis With.	Aug. 04			MD
	yland now at		10a. State 10b. County	10c. (	City, Town o	r Location				1	10d. Inside City Limits
	e Mar 3a-f sh tiffied	Director	Maryland Howa	ard		E	lkridge				1 □Yes 2 □No
	with th		10e. Street and Number 6333 Merle Way			10f. Zip Code	01055		10g. Citizen of V		•
	ns 23 must	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S.	13. Was Decedent of If Yes, specify Cu	21075 Hispanic Origin? (S	pecify Yes or No-	14. Race	US <i>I</i> e - Americ	A can Indian,
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		If Yes, specify Cu 1 ☐ Yes 2 ☐ No		o Rićan, etc.)	Specify	k, White,	<sup>etc.</sup> √hite
<u>.</u>	"natur	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. De	ecedent's Usual Occu ive kind of work done e. DO NOT use retin	upation e during most of wor	king	16b. Kind of Bu	siness/In	dustry
717	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n fraumatic event, the Medi	Completed	Elementary/Secondary (0-12) N/A	College (1-4or 5+)	- 11	ne. DO NOT use retire N/A	ea)		N/Z	Д	
D	al Hyg	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Nan	ne (First, Middle,			
ylan	Ment I Ment	짇	Anthony E.	Ero			Wanda	Blair			
Z	nd 2 sh ulth and 27 is n r traun		19a. Informant's Name/Relationship ( Anthony E. Ero	(father)		lailing Address <i>(Stree</i> 3 Merle Wa				State, Zip	) Code)
e,	of Health of Health I Item 27 I		20a. Method of Disposition	20b	. Place of D	isposition (Name of crematory or other pla	anal	Date	20c. Location -	City or To	own, State
	: Pages tment of i tant: if ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	(y) / M		Crematory	Inc. Aug	008	Baltimo:	re, N	Maryland
Palt	permit. Page Department of Important: If any Injury or once.		21. Signature of Euneral Service Lies	Hallen	1)	22. Name and Addi	ress of Facility ntain_Roa				ome, P.A. 22
			23a. Part Enter the disease, or conshoot, or heart failure. List only	plications that the description one cause on each line.	th. Do not	enter the mode of dy	ving, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Persisten		lmonary 1	Artery h	pertens	ion		
	Examiner		<b>1</b>	7 1 1	Wint	growth	ristrict	im			Leday
ž	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of)	6		0			4 day
	execute and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons		egnony (	Iriplet			$\rightarrow$	4 days
58/60,	ficate be executed physician and is the burial-transit	edical	(	a. Preter	2	26 Week				_	7>
POX P	certific nding p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg	gnancy				23d Dat	te of delive	on
Ö.	w requires that the death certi s been signed by the attending should be detached for use a	Physician/M	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown		3 ☐ Ectopic pregnan 5 ☐ Other (specify)				nth	Day Year
ecords, r	law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not r	esulting in th	e underlying cause g	iven in Part I.		,		he cause of death? bably 4
ဝပ္ပ	law reas bee	Completed	Neutropenia					24a. Was autop		Were auto	opsy findings available ompletion of cause of
VIII H	sician: The law s certificate has t lirector, page 2 s	Com	RIO Sepsis						med?	death?	2 □ No
	Physician: r this certificaral director, I	) Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	T.F.B/O. t-		ther:	th (Check only o			
0	ig Phy ter this neral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tim	ne of 28c. Inj	4 □ Nursing F	lome 5 Resid	ence 6 LOth ow injury occurr		5/)
SIOL	tendin eath. tor: Af the fur	catio	1 ⊠Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	1		M 1[	Yes 2 No		<u></u>		
DIVISION	tal or At s after d al Direct ed in by	Certification:	4 Homicide determined		t home, farm ec <i>ify)</i>	, street, factory, office	9	28f. Location (S City or Tow		er or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier  (Check only one)  Certifying Ph  2 Medical Exam	nysician: To the best of my k miner: On the basis of exami and manner stated.	knowledge, o ination and/o	leath occurred at the or investigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place,	and due t	stated. to the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	V MN			nse number		29d. Date signed	d (Month,	
•	n <				tem 23a) (Ty			301 4			
	<i>O</i> Sta	ite	30. Name and address of person who $\leq \mathbb{H} \setminus \bigvee \leq \mathcal{N} \setminus \mathbb{H}$ 31. Date filed (Month, Day, Year)  AUG 1. 2 2	32. registrar's Siç	nature C	4 MEDICA	ou enill	1	Marylan	.cl_	1
	Registr	ar	AUG 1-2 2	008 300	D.	THE PARTY.					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25792 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Ernest Parker Espinosa 2008 August 4:27 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Manor Nursing Home N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Hours **X** M 2□ F Days 72 Director 578-48-7436 June 11,1936 Washington DC Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at 1XXes 2 □ No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21211 2095 Rockrose Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1XXes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "n. United States Elementary/Secondary (0-12) College (1-4or 5+) Senate Staff 12 Senate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Espinosa ပ္ Ida Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traun once. Jharad Espinosa Son 142 Sandalwood Court, Walkersville, MD 21793 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 8/11/2008 Glen Burnie, Maryland 21. Signatur of Funeral Service L 22. Namme and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final booken **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician a Box 68760. Physician/Medical use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the s d be detached for Ö 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy page perform certificate 2 □No 1 ☐ Yes 1 ☐Yes 2 ☐No the Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of \_\_ath (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation hours after death. neral Director: / 1 ☐ Yes 2 🗌 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hin 24 hours athe Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31464 Name and address of person who completed cause of death (Item 23a) (Type, Print) , 821 N. ENTAW ST Soute JOS BALTIMORE MI) 21201 Hastoni MD UHDA113 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 2008 8:45 A M August Frank Emery Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 406 North Milton Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 13 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Hours Months Days June 1945 218-44-2278 63 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f show ediçal Exaπiner must be notifled at Baltimore 1 XYes 2 ☐ No Director Maryland NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 U.S.A. 406 North Milton Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 [2] Yes 2 No If Yes Bilded Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes X☐ No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 10 Meat Cutter Esskay Meats Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce. ဂ္ဂ Frank E. Emery Sr. Jeanette Spencer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie Emery ( Wife 406 North Milton Avenue Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 14. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2008 bak Lawn Cemetery East Point, Maryland 22. Name and Address of Facility Chojnacki Funeral Homes P.A. 21. Signature of Funeral Service License 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician Dulmonary /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Fo the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has t rector, page 2 s autopsy performed? 1□ Yes 2√□ N 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death
Natural
Control
Accident 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 Yes 2 No Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

Stephanie

31. Date filed (Month, Day,

MUZOX

Year)

AUG

Greene Street Baltimore Maryland 21201

ted cause of death (Item 23a) (Type, Print)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Charles K. Fisher 8-4-2008 3:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto. Stella Maris Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 2-17-1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Months Days Hours Min. **Director** 78 <u> 217-26-6520</u> Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Modical Examinat must be motified at Director 1 ☐ Yes 2 No Md. Balto. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21234 Funeral 9134 Simms Avenue death 12. Was Decedent Ever in U.S. Armed Forces? 1∰Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White 2 Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1.2 should be filed within hand Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Foreman Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2008 Godfrey L. Fisher Frances F. Beck ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tratonce. Wife 9134 Simms Avenue Parkville, Md. 21234 Lorraine D. Fisher 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State AUGUST Pages 1 8-8-2008 Highview Fallston 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a con a quence of): Examiner Sequentially list conditions, if any leading to humanitate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) be executed sician and burial-trans Due to (or as a consequence of) physician the burial Physiclan/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) of Vital Records, P.O. 1 ☐ Yes 2 ☐ No. 9 Unknown cate has been signed by , page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2**X** No after death.

Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation

FISHER CHARLES

> 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2000 ollhood 8-508 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

filled in by the

To the Hospital within 24 hours a To the Funeral E

3 ☐ Suicide

4 Homicide

6 ☐ Could not be

2

AUG 1

determined

EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 2. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar	or waryic	•	tificate of L	Death		eg. No. 2008	25795
Physiciar		. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death 5:55A M
/Medica		Agnes Grace Foreman			di Cit. Tour	Location of Death	8-9-	4c. County of Deatl	J.JJA
Examine	r 4	a. Facility Name (If not institution, give street an Harford Gardens Nursi				to.		4c. County of Beat	·
		Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birtl	nplace (State or Foreign untry)
Funeral Director		217-24-2628 1□ M 2⊠  Jsual Residence of Decedent	F 94	Yrs.	Months Days	Hours Min.	4-8-191	4 Penn	sylvania
and w	-	Oa. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
Maryl	5	Md. Balto.		Es	sex				1 □Yes 2 🛣 No
r 28a	ec	0e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
h with	<u>a</u>	8620 Kelso Drive A	pt.113		21	1221		USA	
deat	Funeral Director	11. Marital Status 12. Was	Decedent Ever in d Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
Irs a	2	If Ye	d Forces? 'es 2∭No , Give or Dates:		1 □Yes 2X No	Specify:		Specify: W	hite
72 hou	Completed	15. Decedent's Education (Specify only highest grade complete	ted)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most of work	ing	16b. Kind of Business/	Industry
Lal ylallo 4 14	E	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	Retai		-7		Department	Store
filed Hyginal Sther	e P	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, I	Maiden Surname)	
should be filed within the Manual Hygiene. I marked other than umatic event, Ire Manual Hygiene.	0	William A. Crist				Belle	Yarnell		
and Nama		19a. Informant's Name/Relationship (Type. Prin		19b. Maili	ng Address (Street	and Number or Rui	al Route Number	r, City or Town, State, 2	Zip Code)
T, Ma 1 and 2 Health a tem 27 is		Shirley Vallar	DTR.	. 5: (5:	5103 Hold	ler Ave.	Balto. M	d. 21214 20c. Location - City or	Town State
Profit		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal		cemetery, cre	matory or other plac	ce) ¦		,	Town, Otato
mit. Pages partment of portant: If if y Injury or ce.	r	4 □ Donation 5 □ Other (Specify)			of Faith		-2008	Balto.	-
permit. Pages 1 Department of 1 Important: If ite any Injury or ot once.		21. Signature of Funeral Service Licensee	eer	-   -				ek Funeral	
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	hat caused the d	leath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
Physician	1	Immediate Cause (Final disease or condition	Cardi	ac v	Agrest				
/Medical Examiner		resulting in death)	e to (or as a con	sequence of):	doto	1. 15	00 71 00		
_	<u>.</u>	Sequentially list conditions,	e to (or as a con	sequence of):	JAN	ry ai	cruse		7
Tusit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Hu	posto	MAINX	1			
exection and and rial-tra	Exa	resulting in death) Last	ie to (or as a con	equence of):		-			
law requires that the death certificate be execute as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	d							
ertifica ing ph	Med	IF FEMALE:							
<b>BOX</b> sath ce attendifor use	ian/	23b. Was decedent pregnant in the past 12 months?	s, outcome of pre Live birth 2□ I Pregnant at time	Fetal death 3	☐ Ectopic pregnand	су		23d. Date of de Month	Day Year
he de	ysic		Unknown	ordeam 5	Other (specify) _				
on or vital records, P.O. box ding Physician: The law requires that the death cer h. After this certificate has been signed by the attendir funeral director, page 2 should be detached for use	h h	Part II. Other significant conditions contributing	to death but not	resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
cords, v requires t been signe should be c	g p	sementia, L	JD _				1 □ Y	es 2□No 3□F	robably 4 Unknown
w rec	Completed by	,					24a. Was a	an 24b. Were a	utopsy findings available completion of cause of
The lay ate has page 2	E O						perfor	med 🚧 I death?	s 2V2No
VITAI sician: T certifica rector, pa	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only o	•	
OT VITA Physician: r this certific ral director,	일	examiner? 1 Yes 2 No Hospital		2 ER/Outpatie	ant 3 LI DOA			dence 6 ☐ Other (Sp	ecify)
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SIO ttendi	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Place of Injury	At home farm s	M	]Yes 2□No	28f. Location (5	Street and Number or F	Rural Route Number,
DIVISION ( I or Attending F after death. I Director: After d in by the funer.	Certification:	4 Homicide determined	building, etc. (S)	pecify)	aroot, lactory, cirioo		City or Tou	vn, State)	
DIVISION  To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only constitution of the	the basis of exa	/ knowledge, dea mination and/or	ath occurred at the t investigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and du	as stated. le to the cause(s)
thin 2 the mplet	Medical	29b. Signature and title of certifier	manner stated.		29c. Licen	se number		29d. Date signed (Mor	nth, Day, Year)
Z 3 Z 8	-	May MD			6	4493		08-12-	2008
1		30. Name and address of person who complete	d cause of death	(Item 23a) (Type	Print)	- A D 1	T	08-12-	1001
9	1	yorana sange.	121 Non	th Euti	un Alha	cet, Bal	umel	re MINX	1201
Sta	te	31 Date filed (Month, Day, Year)	32. Registrar's S	Signature	STARLE STARLES				

08-05957 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 25796 Anna Fields State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death hysician/ Month Year Mė 0420 hrs Examiner August 4, 2008 ANNA FIELDS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore 5. Social Security Number UNK 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Min Months Davs Hours Director Country) SC M 2 X F 74 05-12-1934 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No or items 23a or 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Nathell Hygiens. Department of Health and Nathell Hygiens. If in marked other than "natural", or items 23a or 28a-f shou fun portant: If item 27 is marked other than "natural", or other transmite event, the Medical Examiner must be notified at once, injury or other transmite event, the Medical Examiner must be notified at once. MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2323 W. LANVALE STREET 21216 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No If Yes, Give Year Yes 2 X No specify: Widowed 4 Divorced Specify. þ BLACK 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. MD 21215-0036 10 HOUSE MOTHER HOME 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be THADDEUS FIELDS ELLA WHETSTONE 19a, Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TANGERINE STEWART /NIECE 2323 W. LANVALR STREET. BALTO., MD 21216 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State ltimore, Burial 2 X Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify: METRO CREMATORY 8/12/08 BALTO., MD 21. Signatue uneral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC æ 1701 LAURENS ST., BALTO., MD 21217 23a. Parl I. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval ysician failure. List only one cause on each line een Onset and /Medical Death Narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit ca 23a,27,28a-f, perME, g882 8/13/08 TT X UNPENDED attending physician or use as the burial -Physician/Medi Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown ned by the a detached fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed rector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other ဥ 1 V Yes funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2 X No Pending filled in by the Fnd 8/4/08 Fnd 4:00 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2323 W. Lanvale St 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide (Specify) Homicide house completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. August 4, 2008 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) AUG 1 2 2008 32. Registrar's Signature State Tasker Registrar

DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 9 Day AUGUST 2008 KENNETH JOSEPH FREYE 5:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST HOSPICE TOWSON Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 27, 1916 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**x** M 2□ F Months Days Hours 213-09-1625 91 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits other traumatic event, if a Madical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No BALTIMORE FULLERTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3910 WALNUT AVE 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married Married WHITE 1 ☐ Yes 2 ☐ No ģ If Yes, Give Year or Dates Specify: Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR STEEL COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM FREYE MARIE BINAU ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY FREYE-WIFE 3910 WALNUT AVE BALTIMORE, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ortant: If it Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Important: If any Injury or once: 4 ☐ Donation 5 ☐ Other (Specify) HOLY REDEEMER CEM. 8/12/08 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disc come that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death shock, or heart fallere Immediate Cause **Physician** logopupniale disease or condition resulting in death) indrant of /Medical ue to (or as a consequence Examiner chromania dura Sequentially fist Conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence Certification: To 1 Yes 6 Other (Specify) Wor in 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 30. Name and address person who completed cause of death (Item 23a) (Type, Print) J-CHANCES M Nichorly or torrisin up 2 6201

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Maryland		rtment of H tificate of L			. <sub>No.</sub> 200	8 25798
	Physici	an	1. Decedent's Name (First, Middle, Las	0				Date of Death     Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	7 (2020)	22 E	Ab Ciby Town or	Location of Death	August	08 Zoo	
,	Examin	er	1) Con Con	ORIAL HOSPI	127	1	MORE		40. County of Dea	
	Funeral		5. Social Security Number 6. S	7. Age (In yrs. Is		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bi	rthplace (State or Foreign ountry).
	Director		Usual Residence of Decedent	88   SB	Yrs.			172050H	1530 1.1	ARYLACO
	yland how		10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	8a-fs	Director	nealean	BA	Tirs	ORE				No Yes 2 No
	with the or 2		10e. Street and Number	ar 10.		10f. Zip Code	_ \	10g	. Citizen of What C	ountry?
	death	Funeral	3815 G L 1000 C	12. Was Decedent Ever in U.S	6. 13. W	/as Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	erican Indian,
36	hours after death with the Maryland tural", or items 23a or 28a-f show at Exacultur must be notified at		1 Never Married 2 Married	Armed Forces? 1-☑Yes 2 ☐ No If Yes, Give	1	Yes, specify Cuba □Yes 2♥ No	Specify:	Rican, etc.)	Black, Whi	te, etc.
Ö	hours tural"	ed by	3 Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a. Decede	ent's Usual Occupa	ation	16	b. Kind of Business	3/\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
21215-0036	be filed within 72 hours after death with the Marylan ttal hygiene. ed other than "natural", or items 23a or 28a-f show event, it a Medical Examirer must be notified at	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	(Give k life. D	rind of work done of NOT use retired	during most of work f)	ing		,
	e filed within al Hygiene. I other than " vent, It a Me	Con	10783-		721	HNICIE		45	JOXXX	<u> </u>
Maryland	ild be fil fental H rked otl tic ever	Be C	17. Father's Name (First, Middle, Last)	Encourage			18. Mother's Name	e (First, Middle, Ma	iden Surname)	F 0
ary	2 should be and Menta is marked sumatic ev	Ţ.	19a. Informant's Name/Relationship (7		19b. Mailing	g Address (Street a	and Number or Rur	al Route Number, C	City or Town, State,	Zip Code)
	alf 27		MICHAEL F. G.	2 Jane	3205	ilvials	AF ORIV		TANSBU	
JOre	ages 1 a nt of Hea : If item		20a. Method of Disposition  ↑★ Burial 2 ☐ Cremation 3 ☐	Removal from State	ace of Dispos emetery, crem	ition (Name of atory or other place	e) 8-13	_	c. Location - City of	Town, State
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		4 ☐ Donation 5 ☐ Other (Specify  21. Signa : et Funerál erv e Licen	1 01	RRISO 22.	Name and Address		10	FRRISOR	1 HANDAND
Ba	Depa Impo any Ir		Man Lord	7	18	VANJ FUN	TRALLAR.	PEL+ CRE		128/2000 AX
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	cations that caused the death	. Do not ente					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Chronic  Due to (or as a consequ	obstr	netive	pulnon	y dse	esc	Onset and Death
Y	/Medical Examiner			Due to (or as a consequ	ence of):	eart t	·	,		
	₽ #	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Congesti: Dim to (or as a consequ	vince of):	earl 1	ailwe			1 syeus
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. ARRhift Due to (or as a consequ	h mi	4				> 3 wanth
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_	rtificat ng phy as the	<b>Aedical</b>	IS SERVICE.	o	en i d					/ 2 4 NOWS
Вох	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. if yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 🗆	Ectopic pregnancy	y		23d. Date of de Month	elivery Day Year
P.0.	the de y the a ched f	ysic	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5□	Other (specify)			inc.	54,
	e law requires that the de has been signed by the e 2 should be detached	by Ph	Part il. Other significant conditions of	ontributing to death but not resu	Iting in the und	derlying cause give	en in Part i.	23e. Did toba	cco use contribute	to the cause of death?
ord	equire een siç ould b	ted t						1 ☐ Yes	2 No 3 F	Probably 4 Unknown
3ec	e law r has b e 2 sh	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Ta Ta	iclan: Th certificate ector, pag		25. Was case referred to medical				00 Pl (P (			s 2 <b>X</b> No
Division of Vital Records,	Attending Physician: The sr death. ector: After this certificate h. by the funeral director, page	lo Be	examiner?	Hospital: 1 1 Inpatient 2 ☐ I	ER/Outpatient	3 □ DOA Othe	or:	h <i>(Check</i> o <i>nly</i> o <i>ne)</i> ome 5 ☐ Residend	ce 6 ☐Other (Sp	ecify)
0 0	Jing Ph T. After th funeral	C:uo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	y at	28d. Describe how		
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Ξ	al or A s after al Dire ed in b	Certification: To	4 ☐ Homicide determined	building, etc. (Specify	)	or, ractory, emoc		City or Town,	State)	io, a riodio ranizo,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of my know liner: On the basis of examinat	vledge, death ion and/or inv	occurred at the tin	me, date and place, pinion, death occur	and due to the cau	se(s) and manner a	as stated. le to the cause(s)
	To the I within 2 To the I Complet	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. License			. Date signed (Mor	
	7		Alow Elic Alc	heikh MD				46	August	08-2008
1	2+1		30. Name and address of person who		23a) (Type, P	rint)			1.1	08-2008 ND
10	ス イ / Sta	te.	31. Date filed (Month, Day, Year)	Alcheith  32. Registrar's Signat	ure	union	Memori'-	Hospi	ra'i /	· 1/J
	Registra		AUG 12	32. Registrar's Signat	IN SA	sale				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1 - For State Registrar Decedent's Name (First, Middle, Last) Delores Romaine Green 2. Date of Death AMonth Day 2008 1.05 A M 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) GETTE CTESH POWNIE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) BALTIMORE WALHINGTON MEDICAL AMIR ARUNIDE 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 1 □ M 2 K F Months Maryland 220-30-5274 75 17,1933 Jan. Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c City Town or Location 1 ☐ Yes XXNo Baltimore Brooklyn 10f: Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 209 Southerly Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes \_ 2 ZNo 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Private Homes <u>Domestic Engineer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Pinkney Mary Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wendell Pulley, Sr./ Son 209 Southerly Road Brooklyn, MD 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Zion U.M. Ch. Cem.8/11/08 Pasadena, MD Mt. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 arris Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SERSIS disease or condition resulting in death) Due to (or as a consequence of): PEBRONARULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DINERSTIME Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner Examiner

be executed

Box 68760,

Division of Vital Records, P.O.

Physician /Medical

Examiner

MD

Director

Funeral

9

Completed

**Funeral** 

Director

show

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, its "Medical Exarcination in the motified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Physician/Medical Hospital or Attending Physician: The law requires that the death certificate 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physistely filled in by the funeral director, page 2 should be detached for use as the to the funeral director, page 2 should be detached for use as the total filled in by the funeral director, page 2 should be detached for use as the total filled in by the funeral director, page 2 should be detached for use as the total filled in by the funeral director. Completed Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 2 🗷 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Man r of Death 1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 ☐Could not be

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28b. Time of Injury 28c. Injury at Work?

1 ☐Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Glen Burnie ms 20161

(Check only one) 29b. Signature and title of certifier

ME

29d. Date signed (Month, Day, Year)
August 6 - 2008

State

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAGOTE 31. Date filed (Month, Day) Year)

Hospital elsive 32 Registrar's Signature

Registrar

e Funeral C

within 2

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25800 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Juanita W. Gilless 08 09 2008 11:21PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Severna Park <u>Anne Arundel</u> 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-14-1929 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 🛣 F Months Days Hours Mir 78 Yrs Director 402-40-5452 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, I'm Medical Examinations to other traumatic event, I'm Medical Examinations. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XNo MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 Shamrock Court Funeral 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher 4 Teaching 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Richard Wilford Katherine Patterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Teresa Tracey / Daughter 908 Shamrock Court Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department o Important: If i any injury or once. 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Maryland Vets. Cem. 08-15-2008 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility  $Singleton\ Funeral\ \&\ Cremation\ Srv$ 908 Shamrock Court Glen Burnie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Box 68760, Due to (or as a consequence of) physician IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify). P.O. 1 ☐Yes 2 No 9 ☐ Unknown detached 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ! 2 No 1 Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) F5575+ 1 □ Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. 28d. Describe how injury occurred Injury at Work? Natural 5 Pending investigation death. reral Director: 2 Accident 1 ☐Yes 2 ☐No the 1 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

within 24 hours

State Registrar 29b. Signature and title of certifier

filed (Month, Day,

Year,

2008

AUG 12

0. Nan

cense number

29d. Date signed (Month, Day, Year)

and manner stated.

cause of death (Item 23a) (Type, Print) 109

32 Registrar's Signature

	For	State of Maryland / Department of Health and
-	State Registrar	Certificate of Death

			1 _ For State	State of M	larylan		artmen <i>rtificat</i>			and N	lental Hy		2000	2000
			Registrar  1. Decedent's Name (First, Middle, L	act)			uncai				2. Date of De	Reg. No.		3. Time of Death
	Physici /Medi		MAX GAEE								Month AUG	Day	2008	2:30 AM
-	' Examir		4a. Facility Name (If not institution, g	ive street and number	)	-	4b. City,	Town, or	Location of	of Death			County of Death	
-			HOWARD COUNTY	1 GENERA	e Itos	PITAL	C	olur	NSIA				HOWAR	-o
	Funeral			Sex 7. A 1 ☑ M 2 ☐ F		ast birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bit 12/12/	th	9. Birth	place (State or Foreign
	Director		206-07-4692 Usual Residence of Decedent		95	Yrs.					12/12/	1912		POLAND
	land		10a. State 10b. County		10c. City	, Town or Lo	cation						Ţ.	10d. Inside City Limits
	Many a-fsh	ctor	MD HOWARD	)		COLU	MBIA							1 □Yes 2 No
	or 28	Dire	10e. Street and Number	_		-	10f. Zip		_			10g. Citiz	zen of What Cou	ntry?
	ath w	la	6336 CEDAR LANE,					2104					USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinating the recitind at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2(🔏 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 DYes 2 If Yes, Give Year or Dates	?		Was Deced If Yes, sped 1 □ Yes		ispanic Ori n, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 1	14. Race - Ameri Black, White, Specify: WHI	etc.
9	2 hou	bel	15. Decedent's B	ducation		16a. Dece	dent's Usua	al Occup	ation			16b. Kin	nd of Business/In	dustry
215	hin 7: e. an "n	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or	5+)	(Give	kind of wo. DO NOT us	rk done d se retired	luring mosi )		ing			
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Maryland 21215-0036	ould be file Mental H arked oth	To Be	17. Father's Name (First, Middle, Las HARRY	:t)	GREEN	Ň				er's Name REBE(	e (First, Middle	, Maiden S		NFELD
Jar	2 sho and risma		19a. Informant's Name/Relationship			1	-						Town, State, Zij	
	1 and Health em 27 ther t		GLORIA GREEN / 20a. Method of Disposition	WIFE	20h Di								BIA, MD	21044
Baltimore,	Pages ment of l ant: If its ury or o		1 Misurial 2 □ Cremation 3 L 4 □ Donation 5 □ Other (Special	☐ Removal from State	MT.	ace of Dispo emetery, crer LEBA	NON	ther plac	e) C		Date 1/2008		cation - City or To _PHI,MD	
Balt	permit. Depart Import any inj		21. Agriculte of Füheral Service Lice	Misee A WG 21			2. Name an 8900						& BROS. ESVILLE,	, INC. MD 21208
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List onl	nplication that cause	d the death	. Do not ent	er the mod	e of dyin	g, such as	cardiac	or respiratory a	ırrest,		Approximate Interval Between
-	Physician	9	Immediate Cause (Final disease or condition	// /	Eumo	AIM							1	Onset and Death  5 DAYS
_	/Medical Examiner		resulting in death)	Due to (or as										
		-e	Sequentially list conditions,	b. Due to (or as	a consequi	ence of								
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39	ertific ling p	Med	IF FEMALE:											
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æ		E	CONGESTIVE II		ALLUY							psy ormed? 2 46	prior to co death? 1 ☐ Yes	empletion of cause of
Vital	Physiclan: this certific	Be (	25. Was case referred to medical examiner?						26. Place	of Deat	h (Check only		12.00	2 3 110
of	Physi r this o ral dire	၉	1 Yes 2 No			ER/Outpatier			4 □ Nu	irsing Ho	me 5 Res	dence 6	Other (Speci	fy)
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<u>5</u>	pital or Att ours after d eral Direct filled in by t	Certification:	4 Homicide determined	building, e	tc. (Specify	)	- 51, Idololy,	511100			City or To	wn, State)	, vuniver or Aur	al Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying P	thysician: To the best miner: On the basis and manner s	of examinat	vledge, deat ion and/or in	h occurred vestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, ith occur	and due to the red at the time.	cause(s) date and	and manner as place, and due t	stated. o the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	e signed (Month,	Day, Year)
		- 1	D .001.	~~~				0	2697	7.	1	A-	12 13	2 578

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State Registrar

31. Date filed (Month, Day, Year) AUG 1 2 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATUKENT PKWY

	1 - For State Registrar	State of Maryland	/ Departme		th and M	ental Hygi	g. No 20 (	08 25802
Physician /Medical /Examiner	DANIL  4a. Facility Name (If not institution, give		4b. Ci	GILLER ty, Town, or Loca	ition of Death	2. Date of Death Month August	Day	Year OI = 40 AM  To beath
Funeral Director	210-17-0304	ENT & NURSING  A Age (In yrs. las  76			nder 24 Hrs. urs Min.	8. Date of Birth Month, Day 05/12/1	BALTII 932	MORE  9. Birthplace (State or Foreign County) RAINE
death with the Maryland me 23a or 28e-1 show trinust be notified at neeral Director	Usual Residence of Decedent	, ,	TIMORE	Zip Code		10	g. Citizen of Wi	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	1 RUSSERN COURT  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2 - B  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was De	212 cedent of Hispani pecify Cuban, Me 21X No Spe	ic Origin? (Spe ixican, Puerto I		14. Race	USA - American Indian, , White, etc. WHITE
led within 72 hours aft lygiene. her then "neturel", or nt, the Medical Exem. Completed by F	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 10	cation le completed) College (1-4or 5+)	life. DO NOT	work done during use retired) BARBER		ng		ONAL CARE
d 2 should be filed within the and Maharal Hygiene. 77 is marked tother them traumatic event, the M. To Be Comp	17. Father's Name (First, Middle, Last)  KHASKEL  19a. Informant's Name/Relationship (T)	vna Print)	GILLER 19b. Mailing Addre		POLYA	(First, Middle, M	ΑΑ	ISENBERG
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requires been sign hould be	Part II. Other significant conditions co	ntributing to death but not resultii	ng in the underlying	g cause given in F	Part I.	23e. Did toba 1 ☐ Yes 24a. Was an autopsy	2. No 3	oute to the cause of death?  Probably 4 □Unknown  ere autopsy findings available for to completion of cause of
ng Physician: After this certifica Ineral director, for: To Be C	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending	1	VOutpatient 3 Db. Time of Injury	Othon	Nursing Hor	perform    1   Yes   2     Check only one   1   Resident   28d. Describe how	ed? de MrNo 1[ J ice 6 ⊡Othei	ath? ☐ Yes 2, No  (Specify)
Attendir death	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	M a, farm, street, fact	1 ☐ Yes		28f. Location (Stre City or Town,		r or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one)  12 Certifying Phy 2 Medical Examil 29b. Signature and title of certifier	sician: To the best of my knowle ner: On the basis of examination and manner stated.	and/or investigati	ed at the time, da on, in my opinion 29c. License num	, death occurre	ed at the time, dat	e and place, ar	ner as stated. Indidue to the cause(s)  (Month, Day, Year)
2	30. Name and address of person who or	empleted cause of death (Item 23	Ba) (Type, Print)	D346		1	2009417	8,2008
State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Signature	np 7	7205	Cutts	level 1	rd 2	1208

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2008 25803 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Peter Frank Anthony Hoff 6:40 A M 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
St. ELizabeth's Nursing Home Town, or Location of Death Examiner Baltimore 7. Age (In yrs. last birthday) 94 Yrs 5. Social Security Number 212-01-3096 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 X M 2 □ F Director Jul. 18, 1914 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 77 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Nectical Experiment in a cutified at 1XYes 2□No Director Baltimore filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 3320 Benson Avenue 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify White 至 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "n Lockheed Elementary/Secondary (0-12) College (1-4or 5+) Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Hoff Emma Helbing ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar 8 Rumford Dr., Unit 304, Catonsville, MD 21228 John M. Dumler - POA permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tra once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of New Cathedral Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ potation 3 □ Other (Specify) 8-8-2008 Baltimore, MD Cemeterv 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit I or Attending Physician: The law requires that the death certificate be executed after death. resulting in death) Last Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for u 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. this certificate has been signed by the al director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendin, within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and man 29b. Signature and title of confirer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mera releas hues Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day OS ear **Physician** 8:15 AM Floyd L. Hawkes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Dulaney Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 225-36-4299 **Director** June 30, 1930 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MD Baltimore 1 ☐ Yes 2√ No Windsor Mill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 3828 Twin Lakes Court 21244 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 152-54 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) truck driver umbrella company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Hawkes Susie Stiff ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is any injury or other trau once. Michelle Hawkes/spouse 3828 Twin Lakes Court Windsor Mills, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Sign ture of Euneral Struke Licenses Ronal S. Wad Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate condition resulting in death) End Stage Renal disease **Physician** /Medical Due to (or as a cons. wence of): Examiner Phonas Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Coronary attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy

Hospital or Attending Physician: The law requires that the death certificate be executed certificate has birector, page 2 s this Director:

Be

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Certification:

Medical

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No performed? 2 **N**O 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29c. License number

H0054424

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours aft To the Funeral Di completely filled in

			1 - For State Registrar	ate of Maryland		rtment of H		d Mental Hy	giene Reg. No	008	25806
	Physici /Medic		Decedent's Name (First, Middle, Last)	Mildra	ed	Harr	ida	2. Date of De Month	, Day	9 2 Year	3. Time of Death
	Examir			rusing Cei	nter	4b. City, Town, or 3 Ci	Itin	1010		ounty of Deat	
4	Funeral Director		5. Social Security Number 218–16–9020  Usual Residence of Decedent  6. Sex 1 □ M	2 X F 7. A ge (In yrs. las		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, Date of Bi	rth ay, Year) 1925	9. Birtl Co	hplace (State or Foreign untry) MD
	Maryland	tor	10a. State 10b. County  MD n/a		Town or Loc						10d. Inside City Limits 1 1 Yes 2 □ No
	or 28	Jirec	10e. Street and Number		<u>L</u> CHIOL (	10f. Zip Code			10g. Citize	en of What Co	untry?
	ath w	rai	1190 W. Northern Parkway A	pt. 220		21210				SA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If Item 27 is marked other than "netural; or Items 23e or 28e-1 ahow appringnty or other traumatic avant. The Medical Examinar must be notified at ance.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1	Vas Decedent Ever in U.S. .med Forces? □ Yes 2 ∰No 'Yes, Give 'ear or Dates:		as Decedent of Hi Yes, sp <i>eci</i> fy Cuba □ Yes 2∑No	ispanic Origin' in, Mexican, Pi Specity:	? (Specify Yes or No uerto Rican, etc.)		4. Race - Ame Black, White Specify Afric	
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ylanc	nould be fi 1 Mental H narked ot natic avai	To Be	17. Father's Name (First, Middle, Last)  James Wilson				Harriet	Name (First, Middle t E. Wilson			
a Z	d 2 st th and 27 ts n traun	J. 15	19a. Informant's Name/Relationship (Type, F Anita H. Williams/ Daught					r Rumal Route Numb Insville, MD	-	Town, State, 2	(ip Code)
Baltimore,	Pages 1 ar		20a. Method of Disposition  1 Surial 2 Cremation 3 Remore 4 Donation 5 Other (Specify)	val from State 20b. Pla		ition (Name of atory or other place	9)	Date 8-08	20c. Loca	ation - City or T	
Balti	permit. F Departm Importar any injur		21. Signature of Funeral Service Licensee	1.10 Vella	22.	Name and Addres	s of Facility		al Hom	e P.A. o	f Balto. Co.
	Physician /Medical		23a. Part. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ns that caused the death. use on each line.  ONCEV  Due to (or as a conseque	of		g, such as care	diac or respiratory a	1	313	Approximate Interval Between Onset and Death
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	ha Hospitt n 24 hours he Funera pletely fille	edical	(Check only 2 Medical Examiner: (	n: To the best of my knowled In the basis of examination and manner stated.	edge, death n and/or inve	occurred at the timestigation, in my op	e, date and pl pinion, death o	ace, and due to the occurred at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
	Total Total	M	29b. Signature and title of certifier	" 1 Chr	np	29c. License	number	91	29d. Date	signed (Month	n, Day, Year)
2	0 1		30. Name and address of person who comple	ted case e of death (Item 2	За) (Туре, Р			mire	Ma	rVla	1 21227
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State of Maryland / Department of Health and Mental Hygiene 2 000

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			5. Social Security N		ice & Pa		(In yrs. las		Rand If Under 1				8. Date of Bir	th	9. Birth	nplace (State	or Foreign
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	ne Ho n 24 † ne Fu	edical	(Check only one)	2 Medica	i Examiner: On t and	he basis of manner sta		on and/or in	vestigation,	in my o	ppinion, de	eath occur	red at the time	, date and p	place, and due	to the cause(	s)
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	/Medic Examin		4a. Facility Name (If not institution, g	rive street and numbe	er)		4b. City, To	wn, or Loca	ation of Death		4c. Coun	ty of Death		
			Montgomery Ge	neral Hosp	pital		0	lney			Mor	tgome	-	
	Funeral Director		5. Social Security Number 6 577-46-6594	. Sex 1 □ M 2 💢 F		la <i>st birthd</i> ay) 6 Yrs.	If Under 1 Months E		ours Min.	8. Date of Birth (Month, Day, Aug 6,	1932	9. Birthp Coun of Co	ace (State or Forei try)District Lumbia	gn L
	pu ,		Usual Residence of Decedent		10- 00	y, Town or Lo						110	d. Inside City Limit	te
	aryla shov	<u>ا</u>	10a. State 10b. County		100. Cit		cation						1 ∐ Yes 2 ⊠ N	
	28a-f	Directo	Maryland   Montgo	mery		Olney	10f. Zip C	odo		11	Og. Citizen of	What Coun		
	with		19021 Riverton	Street				0832			US			
	ms 22	Funeral	11. Marital Status	12. Was Deceder		S. 13. 1			ic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americ		
36	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Eventine must be notified at	by Fur	1 ⅓ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force  1 ☐ Yes 2 If Yes, Give  Year or Date:	X No		lfYes,specify 1⊡Yes 2XX	,	exican, Puerto ecify:	Rican, etc.)	Spec	ack, White, $\epsilon_{ify:}$ Wh:	ite. ite	
9	tural		15. Decedent's		J.	16a. Dece	dent's Usual (	Occupation			16b. Kind of	Business/Ind	ustry	
215	a. B. "In "In E	Completed	(Specify only highest	grade completed)  College (1-4o	or 5+)	(Give life. I	kind of work of DO NOT use	done during retired)	g most of work	ing				
2	filed withii Hygiene. other than ent, the M	Com	Elementary/Secondary (0-12)	College (1 40			Clerk				Phone	Comp	any	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, La	st)				18.		e (First, Middle, N	faiden Surna	me)		
Ž	hould id Me mark matic	ဥ	UNK 19a. Informant's Name/Relationship	(Type Print)		19h Mailir	na Address (S	Street and N	UN Jumber or Bur	N al Route Number,	City or Tow	n State Zin	Code)	
Ž	nd 2 s Ilth ar 27 is r trau		Barbara Cornell,			T				Olney, M	-			
altimore,	s 1 and of Health item 27 other to		20a. Method of Disposition		20b. F	Place of Dispo emetery, crer					20c. Location			
Ë	Pages nent of int: If its iry or o		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ITA I				08/0	8/08	Balti	more,	Maryland	1
<u>=</u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		21. Signature de la Service Lo	ebedy		č	Name and	Address of	Facility Clety (	Of Marvl	and. I	nc.		
<u> </u>	9 9 E # 9	-13	▶ Thomas Greg			2	99 Fre	deric	k Road	Of Maryl Baltimo	re,'Ma	rylan	d 21228 Approximate	17
	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or or shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a	as a consequence as a consequence	uence of):			npHon				Interval Between Onset and Death	H_
8760,	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a conseq	uence of):								
O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	h 2 ☐ Feta nt at time of c	Ideath 3	☐ Ectopic pred ☐ Other (spec					ate of delive	ery Day <b>Y</b> ear	
σ,	that ned by deta		Part II. Other significant condition	contributing to deatl	h but not res	ulting in the u	nderlying cau	se given in	Part I.	23e. Did tob	acco use co	ntribute to th	e cause of death?	
rds	quires an sign uld be	ed by	CHRONIC	2137 1104	THE M	umo	non	DIS	EME	1 □ Ye	s 2 No	3☐ Prob	ably 4 ☐ Unknow	wn
Records,	aw requir as been s 2 should	plete					•			24a. Was a	n 24t	. Were auto	psy findings availab npletion of cause o	ole
Ĕ	: The lav	Completed					·			autops perform	ned?/	death?		"
Vita	sician: The certificate I rector, page	Be (	25. Was case referred to medical examiner?		_				Place of Deat	h (Check only on				
=	Physion this contraction	၉	1 Yes 2 No			ER/Outpatier			☐ Nursing Ho	me 5 Reside			y)	
n N	ding P h. After funera	ion	27. Manner of Death 1 Natural 5 Pending	,	Injury Day, Year)	28b. Time o Injury	M 280	Work?	2 🗆 No	28d. Describe ho	w injury occi	urred		
Division of	Atten deat ctor: y the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be logo Place of	Injury - At ho	ome, farm, str y)		1 □ Yes	2 🗆 110	28f. Location (St City or Town		nber or Rura	l Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b			Physician: To the be										:0
	the Ho lin 24 he Fu ipletel	Medical	(Check only 2 Medical Ex	aminer: On the basis		ition and/or in	ivestigation, ir	n my opinio	n, death occur	red at the time, d	ate and place	e, and due to	the cause(s)	
	Vitt To T	Σ	29b. Signature and title of certifier	7 1			29c. l	License nur	nber		9d. Date sigr			
			Tunt 5	alle	w		r	1259	3×7	1	10000	57 7,	2008	
	6		30. Name and address of person wh	no completed cause o	of death (Iten	n 23a) (Type,	Print)		F	400,0	21-12	1000	2008	
	Sta	te	31. Date filed (Month, Day, Year)	1, 1745 34. Ref	istrar's Signa	ture ture	von co	uni	50112	hoo,	inny	, our	10016	
	Registr		ALIC 19	2008	Belgh S.	13. 1	ASSACE.	7						

			For State Registrar	State of Ma	aryland /	-	rtment of tificate o			lental Hy	/giene Reg. No.	000	3 1	25200
	Physici	an	1. Decedent's Name (First, Middle, I Clyde Earl Jobe	·						2. Date of D	Day		3.	Time of Death
0	/Medic Examin		4a. Facility Name (If not institution, guide Union Memorial H	ive street and number)			4b. City, Town Baltim		on of Death	<u> </u>	4c.	County of Deat		
	Funeral Director		465-88-2149	Sex 7.Ag	e (In yrs. last i	birthday) Yrs.	If Under 1 Yea Months Day		ler 24 Hrs. s Min.	8. Date of Bi (Month, D 04/01	rth ay, <i>Year)</i> /1950	Co	untry)	(State or Foreign
	the Maryland 28a-f show	Director	Usual Residence of Decedent  10a. State  Maryland  Baltimo	ore	10c. City, To		cation							nside City Limits □Yes ※XXNo
	with the		10e. Street and Number 440 Torner Road		·•		10f. Zip Code 2122				10g. Citi:	zen of What Co	untry?	
980	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show urnatic event, the Medical Exprainer; use the northed at	by Funer	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces?  1  Yes 2 1 11 Yes, Give Year or Dates:	Ever in U.S. No 1973— 1974	13. V	Vas Decedent of Yes, specify Co	f Hispanic uban, Mexi		ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White Specify: Whi	e, etc.	idian,
Baltimore, Maryland 21215-0036	d within 72 ho giene. er than "natur fre Medical	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)		5+)	6a. Deced (Give I life. D	ent's Usual Occ kind of work dor 100 NOT use reti rapher	ne durina m	ost of worki	ing	16b. Kir	nd of Business/	Industr	y Engineer
yland	thould be filed withind Mental Hygiene.  marked other than matic event, The	မ္က	17. Father's Name (First, Middle, La Clyde Earl Jobe,					1		e (First, Middle Yayne Ko				
Mar	C1 10 10		19a. Informant's Name/Relationship Bonnie Jenkins (S									r Town, State, 2 .and 212		e)
more,	. Pages 1 and iment of Health tant: If item 27 lury or other tr		20a. Method of Disposition  1  Burial XX Cremation 3  4  Donation 5  Other (Specific Actions)		- 1		sition (Name of atory or other p		1	Date /2008		cation - City or		
Balti	permit. Pages Department of Important: If if any Injury or once.	(	21. Signature of Furneral Service Lie		1207 72									ad 21221
	Physician /Medical		23a. Part 1 Inter the disease, or co show, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each lii	ne. ARDIA	o not ente		lying, such	as cardiac				App	proximate rval Between set and Death
38760,69	Examiner	dical Examiner	Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CORAN	a consequence a consequence	RTEI e oi):	2 Dise	ASE,						YKARCS
P.O. Box 6	eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		Ectopic pregna Other (specify)				2	23d. Date of del Month	ivery Day	Year
	requires tha been signed should be det	Ş	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the un	derlying cause	given in Pa	rt I.		tobacco u	se contribute to □ No 3 🔀 Pr		use of death?
Division of Vital Records,	iclen: The law requires that the decertificate has been signed by the ector, page 2 should be detached	Completed								1 □ Yes	ormed? 2 No	24b. Were au prior to death? 1 □ Yes	complet	indings available tion of cause of No
fVit	nding Physician: th. : After this certifics ? funeral director, p	ro Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 🗆 ER/0	Outpatien	3 □ DOA C	NAT-		n <i>(Check only</i> me 5 ☐ Res		i □Other (Spe	cify)	
sion o	utending Padeath.	Certification: To	27. Manner of Death  1 \( \) Natural \( 5 \) Pending  2 \( \) Accident \( investigat \)  3 \( \) Suicide \( 6 \) Could not	ho		o. Time of Injury		□Yes 2	□No	28d. Describe				
) Divi	r ffe		4 ☐ Homicide determine							City or To	wn, State)			
(g)	To the Hospital of within 24 hours and To the Funeral D completely filled in	Medical		aminer: On the basis o	f examination									
	Vor	Σ	29b. Signature and title of certifier		mJ			ense numbe			29d. Date	e signed (Monti	1, Day,	Year)
<b>–</b>	12 1		30. Name and address of person wh	FLANNERY	eath (Item 23a	a) (Type, F	Print)  MEM	ORIA	z lti	TIGZO	AL	BALTIN	LOR	E MD
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	16 1	marke)							

	1 - For Stete Registrar	(Flank Mildur, 1 a.s.	State of iv	iaryiano			of Dea			Reg. N	<u>2008</u>		
cian dical		e (First, Middle, Las ancis	ŋ Janws	ki					2. Date of De Month	Da	ay Year 09 2008	4.4	
iner		f not institution, give		)		4b. City, To	own, or Loca	tion of Death			c. County of De		
		hattan Be				W.H 4	Pasad				Anne An		
al or	5. Social Security N 278-52-9 Usual Residence of	551 1	M 2□F	ge (In yrs. Ia		If Under 1 Months	Days Ho	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da Jan. 0	ay, Year		Birthplace (State or Foreign Country) PA	
or	10a. State	10b. County		10c. City,	, Town or Lo	ation		_				10d. Inside City Limits 1 □Yes 2 및No	
Director	Maryland Anne Arundel  10e. Street and Number				10f. Zip C		adena	1	10a C	itizen of What C	1.		
	733 Powhattan Beach Road					101. Zip 0		1122		rog. O		JSA	
Funeral	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U.S	S. 13. V	/as Decede			pecify Yes or No Rican, etc.)	)-	14. Race - Am	nerican Indian,	
þ	1 ☐ Never Marr 3 🔀 Widowed	ied 2□ Married 4□Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No		☐ Yes 2		ecify:	nican, etc.)		Black, Wh	White	
Completed	(Spec	15. Decedent's Edicify only highest grad	ucation de completed) College (1-4or	5+)	16a. Deced (Give I life. D	ent's Usual rind of work O NOT use	Occupation done during retired)	most of work	king	16b. l	Kind of Busines	s/Industry	
Son	8				Elect			ician		Environmental El		ntal Element:	
Be	17. Father's Name		len oran				18. N	/lother's Nam	e (First, Middle		,		
10	19a Informant's No	ame/Relationship (7	known		10h Mailin	Addross /	Stroot and Al	tumbor or Du		nkno	or Town, State,	7'- 0- 61	
	Deborah A			(م							na, MD		
	20a. Method of Disp	oosition		20b. Pla	ace of Dispos metery, crem				Date		ocation - City o		
.	4☐Donation	☐ Cremation 3 ☐ I 5 ☐ Other (Specify Ineral Service Licens	) /		n Have	n Ceme		Aug.				e, Maryland	
5	Misc	hell	Drale	My s		3111	Mount	ain Ro	ad, Pas	ader	Tuneral na, MD 2	Home, P.A. 21122	
)	Immediate Cause ( disease or conditio	ne disease or comp rt failure. List only o Final n	ligations that cause he cause on each	d the death	Opo not ente	r the mode	of dying, suc	ch as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
ner.	Immediate Cause (Final disease or condition resulting in death)  a. Congestive Heart Failure  Due to (or as a consequence of):  Coron ary Autery Diseas  Due to (or as a consequence of):  Due to (or as a consequence of):						Rase			years			
al Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C												
Medical	IF FEMALE:		d										
hysician/N	23b. Was decedent pregnant 23c. If yes, outcome pr pregnancy 23d. Date 1 Live bith 2 Fetal death 3 Fetopic pregnancy 23d. Date							23d. Date of de Month	elivery Day Year				
by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1 Yes 2 No 3								to the cause of death? Probably 4 □Unknown				
ompleted											prior to death?		
Be C	25. Was case reference examiner?	· -					26. F	Place of Deat	1  Yes h (Check only o		J	3 2 10	
2	1 ☐ Yes 2 ☐	140	Hospital: 1 ☐ Inpat		R/Outpatient			☐ Nursing Ho	ome 5 Resi	dence	6 □Other (Sp	ecify)	
ation:	27. Manner of Death  1 Matural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  2 Accident investigation  28d. Describe how injury occurred Work?  1 Yes 2 No												
Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		tc. (Specify)					City or To	wn, Stat	e)	Rural Route Number,	
Medical	29a. Certifier (Check only one)	1  Certifying Phy 2  Medical Exam	rsician: To the best iner: On the basis end manner s	of examination	ledge, death on and/or inv	occurred at estigation, in	the time, da	te and place, , death occur	and due to the red at the time,	cause(s date ar	s) and manner and place, and du	as stated. ue to the cause(s)	
Σ	29b. Signature and	title of certifier	Johns	n,	m		icense numi			29d. Da	atersigned (Mon	nth, Day, Year)	
	30. Name and addr		ompleted cause of	death (Item 2	23a) (Type, F	rint)			B	1,00	MP2		
tate	31. Date filed (Mon	(h, Day, Year)	32 Regist	rar's Signatu	re #	er)le	14 110	y w	ואצטעון	114	1-11-7	1061	
trar	N.	IG 1 2 200	18 /	A.	Book	1000							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 0545 M 2. Date of Death **Physician** Benjamin Edward Johnson tuaust 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Seasons Hospice
5. Social Security Number Randallstown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min N 2 □ F Director 1-31-1941 212-36-3203 MD Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location event, the Medical Examiner must be notified at Director 1 XYes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 2503 Violet Avenue, Apt. 21215 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No þ Specify SpecifyAfrican-American 3 Widowed W Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any Injury or other traumatic event, IT-1 906. Vocalist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin E. Johnson Sr. Mary Delotch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5714 Highgate Drive, Baltimore, MD 21215 Joy Johnosn/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-13-08 Baltimore, MD Metro Crematory 21. Signal of Funeral Service Licensee 22. Name and Address of Facility Wile Funeral Home P.A. 638 N. Gilmor Street, Baltimore, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Infrediate Cause () isease or condition resulting in death) **Physician** END STAGE PLEWAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Be Medical Certification: To

P.O. Box 68760. Division of Vital Records,

with the Maryland

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

23a or 28a-f show

, or items

"natural"

than,

law requires that the death certificate be executed burial-trai physician the attending p signed by the a d be detached for has page 2 Hospital or Attending Physician: The certificate this After this funeral c n 24 hours after death.

e Funeral Director; A
bletely filled in by the fu death.

completely within 2.

							.	perf 1 ∐ Yes	2 No	death? 1 ☐ Yes	2 No	
exa	Was case refers examiner?	red to medical	26. Place of Death (Check only one)									
	1 Yes 2 X	No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient 3 □	DOA	Other: 4 Nursing H	lome	5 🗌 Res	idence 6	Other (Spec		
	Manner of Deatl  Natural  Accident	5 Pending investigation		28b. Time of Injury M	28c.	Injury at Work? 1 □Yes 2 □No				occurred		
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact	tory, of	fice	28f. L	ocation City or To	(Street and wn, State)	d Number or Ru	al Route N	umber,
298	(Check only one)	1 XV Certifying Ph 2 ☐ Medical Exem	ysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occurration and/or investigat	red at t	the time, date and place my opinion, death occu	e, and ourred at	due to the t the time	cause(s) , date and	and manner as place, and due	stated. to the caus	e(s)

29c. License number

29d. Date signed (Month, Day, Year) August 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25 MAIN STREET REISTENSTOWN MO Merce

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3X Removal from State Doylestown Cemetery 8/13/2008 Doylestown, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ROSEPSIS unknown /Medical Due to (or as a consequence of): Examiner JEHYDRATION KINOWY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tohacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown DISEASE PARKUNSON s been si 2 □ No . Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an his certificate has b I director, page 2 st autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Standarder 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8/11/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3612 Falls Re 136H MO Salva 32. Registrar's Signature State Registra DHMH 17 Rev 1/2001 ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 25812 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 9, 2008 **Physician** Harry Frederick Jacobs 7:15 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 203 Churchwardens Road Baltimore 
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Mar. 2,

 Months
 Days
 Hours
 Min.
 Mar. 2,
 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** <sup>Year)</sup> 1921 tyCxM 2□ F 183-18-9734 Pennsylvania Director 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County other traumatic event, the Medical Examiner must be notified at 1⊠Yes 2 No N/A Maryland Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 203 Churchwardens Road 21212 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, it a "Modical Examinar in ust once. 12. Was Decedent Ever in U.S. Armed Forces? ★★★Yes 2 □ No If Yes, Give Year or Dates: ₩₩II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes ŽENo Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pennsylvania Public Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+ School System English Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Jacobs Lillian Maude Townsley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Jacobs Summers 203 Churchwardens Road, Baltimore, MD 21212 Son

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otato of Ma	()	Certificate of	Death	Reg.	No D D C	25013		
	Dhuaisi		1. Decedent's Name (First, Midd	le, Last)				Date of Death     Month	Day Year	6. Time O Death		
1	Physici /Medio		BETTY G	UNTHER	JONES			AUGUST	7, 2008	10:15 A M		
	Examin	- 1	4a. Facility Name (If not institution				r Location of Death		4c. County of Deat	h		
		Ш		ssisted Livin		Bel Air	If Under 24 Hrs.	8. Date of Birth	Harford	hplace (State or Foreign		
	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birth	Months Days	Hours Min.	(Month, Day, Ye	ar) Co	uintry)		
	Director		218-26-7524 Usual Residence of Decedent		78			Oct. 26,	1929 Mar	yland		
	yland now at		10a. State 10b. Count	,	10c. City, Town	or Location				10d. Inside City Limits		
	a-f sh	cto	Maryland Harf	ord	Bel Air					1 ☐ Yes 2 XNo		
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?		
	23a ust b	ral	1 Glenwood R			21014			SA			
	er deg	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		<ol><li>Was Decedent of H If Yes, specify Cub</li></ol>	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
36	rsaft I', or kamli	by F	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes Give	10	1 ☐ Yes 2 🙀 No	Specify:		Specify:	hite		
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ODE.	be	15. Decede	nt's Education	16a. E	ecedent's Usual Occup	pation	165	. Kind of Business/			
21215-0036	hin 7; 9. an "n Medi	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4or 5-		Give kind of work done life. DO NOT use retire	during most of work d)	ing				
2	d wit	20		5+		acher			ublic Edu	cation		
Maryland	be file	Be	17. Father's Name (First, Middle					e (First, Middle, Maid				
<u> </u>	ould I Men arke	၉	Christopher (					becca Smi				
<u>Ja</u>	l2sh hand ris⊓ raum		19a. Informant's Name/Relation	ship (Type. Print)		Mailing Address (Street				Zip Code)		
e)	1 and Health	1	Gary Allen Jon 20a. Method of Disposition	es / Son	20b. Place of [	Elenwood Rd Disposition (Name of		r, Maryla Date 1 200	nd 21014 Location - City or	Town State		
altimore,	ages nt of l		1 ☐ Burial 2 反 Cremation		cemetery	, crematory or other pla	ce)					
≣	it. Partime		4 □ Donation 5 □ Other ( 21. Synature of Funeral Service		HITTEO	Service C	_		wson, Mar			
Ba	Deport Impo		Alle MC	Comaster	=	McComas F 1317 Coke	uneral Ho	me, P.A. d. Abingd	on Maryl	and 21009		
г			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that caused	the death. Do no				011, 120272	Approximate Interval Between		
	Physician		Immediate Cause (Final	t only one cause on each lin		e deme	~ -			Onset and Death		
)	/Medical		disease or condition resulting in death)	a. Due to (or as a	a consequence of	1	utes					
P	Examiner		O. C. C. H. Pat and Physics	b		77.11						
7	D #	ner	Sequentially list conditions, if any, leading to immediate Cause (lisease or injury	Due to (or as a consequence of):								
3	ecute Ind trans	Examiner	triat miliated events	с								
90,	oe exician gourial.											
68760,	rificate be executed ng physician and as the burial-transit	Medical	d									
		/Me	IF FEMALE:	23c. If yes, outcome	pf pregnancy	- A- K-			23d. Date of del	iverv		
Box	w requires that the death ce been signed by the attendir should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		Month	Day Year		
P.O.	the c	ıγsi	9 Unknown	9□Unknown								
	s that ned b	by PI	Part II. Other significant condit	ions contributing to death bu	it not resulting in	the underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?		
ğ	equire en sig	ed k						1 ☐ Yes	2 No 3 Pr	obably 4 \ Unknown		
ဝ၁	e law re has ber je 2 shc	plet						24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of		
œ.	The ate hapage	Completed						performed	d?   death?	<u>`</u>		
Ita	ician: Th certificate ector, pag	Be (	25. Was case referred to medic examiner?					h (Check only one)				
Division or Vital Records,	Physic this o	ို	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie		Attent 3 DOA		me 5 Residenc				
n O	ding P. After i funera	Certification:	27. Manner of Death  1 Natural 5 ☐ Pend			ury Wo	rk?	28d. Describe how i	njury occurred	Living		
<u>S</u>	ttend leath stor:	cat	3 Suicide 6 □ Could		ını - At homo farr	M	Yes 2 □ No	28f. Location (Stree	t and Number or P	um I Pouto Number		
$\leq$	or A after of Direction by	ji.	4 ☐ Homicide deter	mined building, etc	. (Specify)	ii, street, factory, office		City or Town, S	tate)	arai noute Number,		
	spital lours neral filled		29a. Certifier 1 Certify	ing Physician: To the best of	of my knowledge,	death occurred at the ti	me, date and place,	and due to the caus	e(s) and manner as	s stated.		
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical		Examiner: On the basis of and manner sta	examination and							
	To th withir To th comp	Me	29b. Signature and title of certification	er		29c. Licens	se number	29d.	Date signed (Mont	h, Day, Year)		
			Dave!	5 331-		037	2215	an	gust 7.	2007		
	20		30. Name and address of perso			ype, Print)	_ Be	al Air, MD	21014	<u> </u>		
	0		DAV. DS 2	60	5 m. 0	macPha./	Ke/.	011				
3	Şta		31. Date filed (Month, Day, Yea.	32. Registra	ar's Signature	macpha.						
	Registi	ar	AUG 1 2 20	108	AT ASA	Carl State of the						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Date of Death Ones 12:00pM 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year 9. Birthplace (State or Foreign Date of Birth Month, Day, Age (In yrs. last birthday) Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Kaltimore 1 Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. Do NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Su Eather's Name (First, Middle Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type. Print) *Hreet* 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ETASTAT MONTHS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

Physician

/Medical

Examiner

**Funeral** Director

28a-f show

**Funeral Director** 

Be Completed by

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov almoprant: If Item 27 is marked other than "natural", or items 29a or 28a-f shov almoprant; or other traumatic event, the Medical Examiner must be notified at one.

1 and 2 should be filed within 72 hours after death with

Pages 1

altimore, Maryland 21215-0036

the burial-tran for use as cate has t page 2 s.

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the To the

State

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGNES CATON AVE BALTIMORE 900 COLE MD

31. Date filed (Month, Day, Year) UG

29b. Signature applittle of certifier

32. Registrar's Signature



28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST Year **Physician** John, Jones 4:50 PM 08 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 3,1920 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days 1XM 2□F 212-12-5105 88 Director MD Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 📉 No Director MD Anne Arundel Linthicum 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or Items 23a or U.S.A.

14. Race - American Indian, 219 Coronet Drive 21090 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Cabinet Maker Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Monnie D. Jones Irene Webster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Debra L. Sherman /Daughter 219 Coronet Drive Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug. 14, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛣 Other (Specify) Mausoleum Loudon Park Cem. 2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01479 Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Kena /Medical Due to (or as a consequence of) **Examiner** Hypernatremia Sequentially list conditions, if any, leading to influence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of): Examiner The law requires that the death certificate be executed ongestive burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by prostate 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should atrial 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an certificate | 1∐ Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESØ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanover street, 3001 Obadina EnTola South

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

AUG

32. Pegistrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav A.M 3008 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2008 VAL If Under 24 Hrs. Hours Min. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) **1** M 2 □ F Months Days 21718 1439 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Microal Expression rust be notified at Director 1 ☐ Yes 24 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ZIOIS Funeral 12. Was Decedent Ever in U.S. Armed Forces? TAYes 2 No IfYes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No <u>م</u> Specify: 3 Widowed 4 □ Divorced DEW Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) W182 Elementary/Secondary (0-12) College (1-4or 5+) 12765. 567. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked othe any injury or other trainmets. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HAY GRIZIA. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21024 19a. Informant's Name/Relationship (Type. Print) JARRIZ RADA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3003 21. Standard of Fundal Service License 22. Name and Address of Facility REMARKIO EVANS FUNCTON 2+159PH ORIVE FOR 23a. Part1. Enter the disease, or compile fins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician can /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underly in Cause (Disease or injury that initialed events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) I□Yes 2□No signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No of Vital 1 □Yes After this certifiin funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home TResidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Natural 2 Accident 4 hours after death.

uneral Director: Af
ely filled in by the fur 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar

10+1

Darl

50

72008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6,5

Registrar's Signature

3008

08-05909	
Louella King	

ouella King	State of Maryland / Department of Health and Mental Hygiene  1-For State Registrar  Certificate of Death  Reg. No. 2 1 1 2	2501
Physician/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time	of Death
Medical Examiner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	4 hrs
	1941 W. North Avenue Baltimore	
Funeral Director	5. Social Security Number 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 1 - 1/- 68  1 Country)	State or YD
yue.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. In	side City Limits
ne Maryland or 28a-f show fied at once.	MD Kaltimore 1X	Yes 2 No
r death with the Maryland or items 23a or 28a-f sh rmust be notified at once Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/2/7 U.S.A.	
s after death wi		an, Black, ر م
2 hour "natu	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  **WSING ASSISTANT**  16b. Kind of Business/Industry  ### WWSING HEAVE  **WWSING HE	e
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical To Be Comple	Billy Roberson Rolange Dursey	
ore, MD 21215-C. Is and 2 should be filed to of Health and Mental Hygi Witen 27 is marked oth per traumatic event, the To Be CC	Kozanne Dirsey Mother 1523 W. Lexington St. Apt 2F Bulto, Ma	21273
E	20a. Method of Disposition  1 Z Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, Secrematory or other place)  Removal from State 20c. Location - City or Town, Secrematory or other place)  Removal from State 20c. Location - City or Town, Secrematory or other place)	
Baltimo permit. Pag Department Important: injury or ot	22. Name and Address of Facility Vaugh 1. Fren Funeral Source Licensee 5151 Rathmere National Pike Batto, Md.	21229
Physician /Medical	23a. Part I. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appro	ximate Interval een Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Alcohol & methadone intoxication  Due to (or as a consequence of):	Death
<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
amin	causs. Enter Underlying Causs (Disease or injury that initiated c.  Due to (or as a consequence of):	
60, are be executed thysician and te burial - transit Medical Exi	events resulting in death) Last Due to (or as a consequence of):  d.	
60, ate be exe hysician e burial -	X UNPENDED 19a, perFH G882 8/12/08 TT 23a, 27, 28a-f, perME, g882 8/13/08 TT	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit edical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Year
). Bo the dea by the a iched fo	1 Yes 2 No 9 V Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the caus	e of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  It Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	1 Ves 2 No 3 Probably 4	<b>✓</b> Unknown
Records,   The law requires ficate has been signed. page 2 should be Completed	24a. Was an autopsy fin autopsy prior to completio	
tal Rec	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
f Vital Rec Physician: The r this certificate ral director, page To Be Con	examiner? [Hospital: [Othor: ]	
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isior - Attencer death	Pending Investigation Accident Accident Strictle of The Investigation Strictle of The Investigation Accident Strictle of The Investigation Accident Strictle of The Investigation Investigation Accident Strictle of The Investigation Investigation Accident Strictle of The Investigation Investigatio	Number, City
Division o spital or Attending Jours after death. neral Director: After filled in by the fune Certification:	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1941 W. Nort Baltimore, MD	h Ave.
Divi	293. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, August 2, 2008	Year)
~ <	30° Name and address of person who completed cause of death (Item 23a)	
0	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	ALIO I D DILLY FEE CONTRACT	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year RUBERT KLEIN 2000 /Medical 09 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deal Examiner SHOCK TRAMMA BINTIMORLE COTY UMMS BALTIMOKE, MD If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Date of Birth (Month, Day, Year) D2 | O1 | 1934 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**™**M 2□F Months 20, -26-6093 Director Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" --- " any injury or other traumatic every" --- " any injury or other traumatic every --- ". 10a. State 10c. City, Town or Location 10d. Inside City Limits mD PRINCE GEORGES 1 res 2 No Director LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2070 15 863 SHERWIND AVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [X Yes 2 □ No If Yes, Give Year or Dates: 1956-58 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ò Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) United States College (1-4or 5+) Government Computer Programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward R. Klein ပ Arline Burke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. Klein /spouse 15803 Sherwood Ave., Laurel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery | Aug 13, 08 | Laurel, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart all the. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): 3 0445 Examiner SPINAL CURD TRANSECTION C2 LEUES Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last EXAMINER Due to (or as a consequence of): .O. Box 68760, Physician/Medical BY MEDICAL REPROTED BY MEUN Month IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Ď 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has to irector, page 2 s 24a. Was an autopsy performed 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred in, Day Year) BOOGEY BURNUNC 5 Pending investigation 1 Natural Injury patient was inK 1 ☐ Yes 2 Accident neral Director: STRUCK HELD IN SAND 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide OCEAN CITY within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09/2000

State Registrar

31. Date filed (Month, Day, Year)

QUAST

32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PULMUNAM CUNIC 22. Registrar's Signature

DHMH 17 Rev 1/2001

NNMC

SETHESDA

WISCONSIN AVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Walter R. Kratz, Jr. State of Maryland / Department of Health and Mental Hygiene 2008 25819 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ August 5, 2008 Walter al Examiner Robert Kratz, Jr. 0850 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore St. Agnes N/A 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Age (In yrs. last birthday) Months Days Hours Director 218-10-1778 89 Country) MD 1 XM 2 F Aug. 1, 1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Marvland Baltimore 1 Yes 2 X No Catonsville with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 709 Maiden Choice LN Apt. 6208 21228 USA 238 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 3 X Widowed WW Divorced If Yes, Give Year Yes 2 X No specify: Specify: White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 h nent of Health and Mental Hygiene. ant: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) partment of Health and Mental Hygiene.
portant: If item 27 is marked other than "
ury or other traumatic event, the Medical. 21215-0036 12 4 Accountant R.J. Taylor Co. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Walter Robert Kratz, Sr. Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M Michael Kratz (Son) 2415 Powder Horn Way, Gambrills, MD 21054 20a. Method of Disposition timore, 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 8/9/08 Baltimore, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Pertil-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician failure. List only one cause on each line, Between Onset and Medical Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician a UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be et.
 24 hours after death.
 24 hours after death.
 25 Hours after the settificate has been signed by the attending physicial stely filled in the stell mereal director, page 2 should be deached for use as the burial stelly filled in by the funeral director, page 2 should be deached for use as the burial. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown q Unknown P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ endstage renal disease, metastatic prostate cancer 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: Other<sub>4</sub> Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification 1 V Natural Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1

To the

Medical

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

OCME

29d. Date signed (Month, Day, Year)

August 6, 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) State 2008

29b. Signature and title of certifie

and manner stated

25 005 M

Name and address of person who completed cause of death (Item 23a)

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** August 30 M 2008 Margaret Gertrude Kre11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL BAHimore WAShington Medical Center GLEN BURNIE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 20XF 80 219-26-3067 Director 03/08/1928 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Exercises roust by a citied at Director 1 ☐ Yes XX No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 107 21060 Furnlea Drive Funeral Germany Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: Specify: Completed by XX Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Factory marked other and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Christian\_Glasser Margaret Schwarzfarber Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) cousin 8 other 1 Mr. Christian Reingruber 2200 Hyden Court, Fallston, Maryland 21047 Baltimore, Important; If item any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/09/2008 | Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility 1 2nd Ave, SW 21. Signature of Funeral Service Licensee Glen Burnie, MD Mo/357 Singleton Funeral & Cremation Services 21061 23a. Part1. Etter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician monde /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician sthe burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) sate has been signed by the page 2 should be detached g  $\square$  Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 🗖 No 1 □ Yes After this certification, funeral director, f 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MI wilms inn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Modia Center we 32 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 2 Registrar

			1 - For State Registrar	State of Maryla	•	artment of r rtificate of			giene Reg. No.		
	Physic	an	1. Decedent's Name (First, Middle, La	•				2. Date of Dea	ath	3. Time of Death	
	/Medi		Wilma DeLayne La					July 2		11:30 PM M	
À	Examir	ner	4a. Facility Name (If not institution, giv 2015 Red River				r Location of Deat sburg	4c. County of Death  Carrol1			
	Funeral Director		5. Social Security Number 6. S 214-26-3764 Usual Residence of Decedent	6ex 7. Age (In yrs	i. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year)	D. Birthplace (State or Foreign Country) Vest Virginia	
	/land		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits	
	Many e-f eh	tor	MD Carrol	1	Elders	burg				1 ☐ Yes 2 ☐ No	
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?	
	s 23s	Funeral Director	2015 Red River R	oad 12. Was Decedent Ever in	11.5 12.1	Man Dansdont of L	21784	Specify Van as Na	US.	A American Indian,	
21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other then "natural", or Items 23s or 28e-1 show imatic event, its Medical Exercipar mast by inclified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🏋 No	Specify:	to Rican, etc.)	Black,	white	
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121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)				
2	Hiled Hygi other	Be Co	17. Father's Name (First, Middle, Last,		barber	18. Mother's Na	me (First, Middle,	Maiden Sumame)			
<u>Ian</u>	uld be Mental irked o	To B	Calvin Guy Lipsc	omb			Emma	Jane Day	7		
, Maryland	C1 62 58 5		19a. Informant's Name/Relationship ( Linda Willis/dau		ng Address (Street 5 Red Riv			City or Town, State, Zip Code) g , MD 21784			
Baltimore,	Pages 1 and 3 ment of Health ant: If Item 27 ury or other tru		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specif	Removal from State	Place of Dispo cemetery, crer	sition (Name of matory or other place	сө)	Date	20c. Location - Ci	ty or Town, State	
Balt	permit. Pages Department of Important: If II eny Injury or o		21. Signature Funaral Save Licer Ronald S	Wade Directo	r S	altimore	tomy Boar	201		ore Street	
			23a. Part1. Enter the disease or comshock, or heart failure. List only	plications that caused the dea one cause on each line.	ath. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death	
ž	Physician /Medical		disease or condition resulting in death)  a.   O(east Carler								
	Examiner		1	Due to (or as a conse	quence of):						
		ner	Sequentially list conditions, if any learny to immediate cause. Enter Underlying Cause (Disease or injury								
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
<b>68/6</b> 0,	tificate be executed ig physicien and as the burial-transit	edical Ex									
			IF FEMALE:								
C. BOX	requires that the death cert wen signed by the attending hould be detached for use a	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1   Yes 2 No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   4   Pregnant at time of death 5   Other (specify)   9   Unknown   9   Un							23d. Date of delivery Month Day Year	
J	s that I ned by e deta	y Ph							Did tobacco use contribute to the cause of death?		
	w requires to been signer should be								1 Yes 2 No 3 Probably 4 Unknown		
Hecord	aw 2 s t	Completed						24a. Was a		re autopsy findings available or to completion of cause of	
	Page T	Con						perfor	med2 dea	ith? Yes 2 No	
VITAI	Physicien: Th this certificete ral director, pag	Be C	25. Was case referred to medical examiner?	Hospital:		• all pos Oth		ath Check only or	7.		
0	g Physer this eral di	٦: ا	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of	1 3 LI DON	4   Nursing r	_	lence 6 Other		
0	ath. ath. or: Afte	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		k? Yes 2∐No		10.		
UNISION	To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Certification;	3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Num City or Town, State)							or Rural Route Number,	
	he Hospi in 24 hour he Funer pletely fill	Medical	29a. Certifier (Check only one) 1 Certifyin Ph	vsician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tir restigation, in my o	me date and bloce pinion, death occu	and due to the ourred at the time, o	rause(s) and mann date and place, and	or as stated. If due to the cause(s)	
)	To t To t	Σ	29b. Signature and title of certifier	2 WD		29c. Licens	e number 40854		29d. Date signed (	Month, Day, Year)	
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Турв,		Parl Pla	ie B	months.	21207	
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 2 20	32. Registrar's Sign	ature	9077					
DH	MH 17 Rev 1/2		HOU I & ZI	108	A STATE OF THE STA						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 8, **Physician** Frances Mary LoZito 2008 2:05 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 30, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 E 220-24-1818 Director 1916 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Medical Examinar must be notified at once. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3109 Orlando Avenue 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ģ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Men's Suits Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stefano Rappazzo Carmella Fazio ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3109 Orlando Avenue Baltimore Marvland 21234 Frances Anderson/Daughter 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/12/08 Dulaney Valley Mem. Gardens Timonium Maryland 22 Name and Address of Facility 5305 Harford Road Baltimore Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably funeral director, page 2 should Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate □Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at a Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 3 Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Le M Karry Burd 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 2008 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a,perFH g882 8/12/08 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LAWS **Physician** DORUT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MUDAI SECOUNS BANTIMMANE HOSPITAL Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore 1 Yes 2 No Director 1918 Sav 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

One of the second of 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawma Viece Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) Crownsville 3 ☐Removal from State 22. Name and Address of Facility Vallyhn 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): NENAL DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine MELLITUS WIH GETES Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ LEFT FOOT 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an HNDETERMINED; ATRIBUTIARALATION 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) moon lel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wow W. V. MOENTREY, mo 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Amend 20b, perFH G882 8/12/08 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST 2008 DAVID E LAZEROW 2:56A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SUBURBAN HOSPITAL MONTGOMERY BETHESDA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/05/1917 Birthplace (State or Foreign Country)
 MD **Funeral** Months Days Hours Min, Yrs. 212-01-2121 91 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f showevent, the Medical Examinational to notified at Director 1 □Yes 2 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT, APT. 424 21117 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No AIR If Yes, Give Year or Dates: CORP 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event. If the literature once. 1 ☐ Never Married 2 X Married 1 ☐Yes 2 X No Specify: 2 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OPTOMETRIST EYE DOCTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be abraham LAZEROVITZ ျှ IDA SACHS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR LAZEROW / SON 8602 LONG ACRE COURT, BETHESDA, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/10/2008 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 4 ☐ Donation 5 ☐ Other (Specify) <del>08/010/2008|</del> REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician HEART FAILURE** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ HYPERTENSION icate has been si 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed HYPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 A No certificate HISTORY OF MYOCARDIAL INFARCTION Vital 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛱 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 🕻 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. (Check only one) within 2 29b. Signature and title of entifier 29c. License number 29d. Date signed (Month, Day, Year) MD D43904 08/07/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEO HELLER, MD, SUBURBAN HOSPITAL, 8600 OLD GEORGETOWN ROAD, BETHESDA, MD 31. Date filed (Month, Day, Year) AUG 12 32. gistrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25825 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 3, 2008 4:40 LAWRENCE B. LIPKA AUGUST 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE TOWSON GILCHRIST HOSPICE Birthplace (State or Foreign Country) If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday If Under 1 Year Social Security Number Days 1 🕅 M 2□ F 83 MDDEC. 16, 1924 216-16-0936 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1X Yes 2 □ No BALTIMORE N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 6816 GOUGH ST 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: 11. Marital Status 1 □Yes 2 No 1 Never Married 2 Married Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) KOPPERS CO. Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY UNKNOWN CASMIR LIPKA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD 21224 6816 GOUGH ST ELIZABETH LIPKA-WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 8/7/08 OAKLAWN CEMETERY 4 Donation 5 DOther (Specify) CHARLES S. ZEILER & SON, 22. Name and Address of Facility 21. Signature of Furneral Service Licens BALTIMORE, MD 21224 6224 EASTERN AVE Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, o shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) WELKS CMP U CATIONS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Year cause of death? 4 Unknown y findings available letion of cause of □No 405P14 1 Yes 2 🗌 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death SHPANO FALL 5 Pending investigation 1 🔲 Natural 1 ☐ Yes 2 No TUNE 25, 2008 UNKNOWN 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

Physician /Medical **Examiner** Examine

**Physician** 

/Medical

**Funeral Director** 

à

Completed

Be

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Examiner

**Funeral** 

Director

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marian Examination on the percentified and once.

Physician/Medical Completed by Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran certificate within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

Division of Vital Records, P.O. Box 68760,

	d	9	X	The state of	•
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)	12	Ti	23d. Date of delivery Month Da
9 Unknown	s contributing to death but not resulting in the u	underlying cause given in Part I.		23e. Did tobacco u	use contribute to the
CORONARY ART	ERLY DISEASE PIL	LIMONARY EMBOLIC	SAL	1 □ Yes 2	□ No 3 □ Probab
gASTROINTEST!				24a. Was an autopsy performed?	24b. Were autops prior to comp death?
25. Was case referred to medical		26. Place	of Death (C	heck only one)	
examiner?	Hospital: 1 Department 2 FB/Outpatie	ent 3 DOA Other: 4 Nu	rsing Home	5 Residence	6 Other (Specify)

6 ☐ Could not be 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME

8832 WALTHER BLUS PALLUIUE, MO

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

D64395

ANGUST 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 NEHHFLES ST, 811 TE 209 DANIEUE DOBERMAN, MO

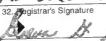
BALTIMORE, MA 21204

State Registrar

Medical

31. Date filed (Month, Day, Year)

AUG 1 2





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25826 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 13:16 PM AUGUST LOUR /Medical 4a. Facility Name (If not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAINT AGNES yrs last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MACCh 13,1934 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** 216-36-5301 Days Months 1**X** M 2□ F MArsland Director Usual Residence of Decedent 10c City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at SAltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 21207 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2NNo Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO JOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname Mailing Address (Street and Number 20a. Method of Disposition 20b. Place of Disposition (Name of pemetery, crematory or other) 2 Cremation 3 Removal from State 4 □ Conatio 5 Other (Specify) 21 Signature LFuneral Service Licensee 23a. F. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or hear failure. List only one cause on each line.

Impress the Cause (Final disease).

SEPTIC SHOCK

The Iting in death)

a. Due to (or as a consequence of the consequence of the cause). Approximate Interval Between Onset and Death **Physician** DAYS /Medical Due to (or as a consequence of) Examiner PNEUMUNIA WEEKS Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of certificate be executed burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ ARDIOMY OPATHY 1 Yes 2 No 3 Probably 4 Winknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA Division or After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Year) (Month, Day Injury 1 Natural thin 24 hours arter control of the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 MI) 21798 AUGUST 10 2008

State Registrar BHAVANDEEP

31. Date filed (Month, Day, Year)

AUG

DHMH 17 Rev 1/2001

JOSEPI

900 CATON AVENUE

BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

BAJAJ

	Funer Direct	Ì
Salar		•
altimore, Maryland 21215-0036	wrnit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ppartment of Health and Mental Hyglene. ppartment of Health and Mental Hyglene. ppartant: if flew 27.2 markede other than "natural; or items 23a or 28a-f show iy injury or other traumatic event, the Medigal Examiner must be notified at iy injury or other traumatic event, the Medigal Examiner must be notified at	

sician and burial-transit attending physician for use as the buria e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the fetely filled in by the funeral To the Hospital of within 24 hours at To the Funeral D

Records, P.O. Box 68760,

Division or Vital

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month ZOFIA MASTET 4:09 PM do, AUGUST 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) AUG 30 1924 Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 213-29-0312 Poland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 823 S. Milton Avenue 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏝 No Specify. ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Matusik Constance UNK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Mastej - husband 823 S. Milton Avenue, Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/8/2008 Baltimore, MD 21. Signature of Funeral Service Licensee
Steven H 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Dept Impo any i Williams 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CONGESTIVE HEART FAILURE Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed' 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 patient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one of cer 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year) MO. RES-001 AUGUST 6,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EMMANUEL GORDSPE, MD/JOHNS HOPKINS BAYVIEW MEDICTE. / 4940 EASTERN AVE, BALTMORE, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**Funeral** 

Director

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State of Maryland / Department of Health and Mental Hygiene StateAmend 20c,perFH G882 8/12/08 Tertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Ruth Ellen Mathews 6:50 P. M 10, August 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holland Manor Assisted Living Baltimore County Towson 9. Birthplace (State or Foreign Country)
Baltlinore, MD 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 08, 1924 7. Age (In yrs. last birthday) 1□M 21 F Months Days Hours Min. 216-16-6364 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1812 Landrake Road uneral 21204 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ite ustrv 9 Code) 21093 n, State MD ngtr.,P.A. Approximate Interval Between Onset and Death > 5 yrs Year Dav e cause of death? ably 4 Unknown sy findings available 2 No Assisted Living Route Number, ated. the cause(s) Day, Year) 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2008 **Physician** Month August 9, Angelina Madonna 12:44 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 3309 Beech Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 212-22-1280 86 Director 1922 Indiana Jan. Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Evaminer must be notified at Director 1⊠Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3309 Beech Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or iter any injury or other traumatic event, Ite Medical Entails and any injury or other traumatic event, Ite Medical Entails and any injury or other traumatic event, Ite Medical Entails and any injury or other traumatic event, Ite Medical Entails and any injury or other traumatic event, Ite Medical Entails and any injury or other traumatic event. 1 ☐ Never Married 2 🖾 Married altimore, Maryland 21215-0036 1 □ Yes ŽŽNo White If Yes, Give Year or Dates: Specify: \$ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elegant Elementary/Secondary (0-12) 12 College (1-4or 5+) Clothing Manufacturing Shipping Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio Di Paolo Marie Scuccimarra ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Madonna Husband 3309 Beech Avenue, Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Lorraine Park Cemetery 8/13/2008 Woodlawn, Maryland 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21. Sign tury of Funeral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PERITONEAL **Physician** OVARIAN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 M No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ZNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 Yes 2 No Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P27730 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAM COHEN ND 6569 N. CHALLET 11. BALTMORE, NO. 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiens 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 3 2008 Year Isabelle Μ. Milkowski 1300 /Medical . Facility Name (If not institution, give street and number) Brinton Woods Nursing & Rehab. Ctr. 4b. City, Town, or Location of Death Sykesville 4c. County of Death Carroll Examiner Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York **Funeral** 8. Date of Birth Days Hours Min 1 □ M 2 □ F 219 22 0293 89 December 18 1918 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Widdial Exercitor in ust be notified a once. Maryland Baltimore Director Baltimore County 1 TYes 2 XTNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7840 St. Thomas Drive 21236 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 XXNo If Yes, Give Year or Dates: Specify. ρ 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-40r,5+) Elementary/Secondary (0-12) Housewife Housekeeping-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Mikos Mary Witkowski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Lake Circle Drive Eldersburg, Maryland 21784 Linda Stanley (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cemetery August 13 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Brain injuri wammatic resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for es a consecuença of Examine attending physician and for use as the burial-tran Due to (or as a consequence of): 68760, Completed by Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) certificate has been signed by the irector, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 1 ☐Yes 2 No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) oxammer? 1 X Yes 2 ∐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural May 18,2008 un Know N M 1 □ Yes 2 XNo 2 Accident +91 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7840 St. Thomas Dr. Baltimore Md 4 Homicide Joine 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 M) 6 LY 32 Registrar's Signature 6 Trimble Hill CT. Lutherville Md 2109 tello 31. Date filed (Month, Day, Year) State 2008 AUG Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day August 9, 2008 **Physician** THOMAS WILLIAM McGINN, JR. 12:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER Towson Baltimore County If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Director 220**-**40**-7**614 65 Dec 1. 1942 Maryland Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Strathdon Way 21093 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 61-6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 61 - 641 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: if Item 27 is marked other that any Injury or other traumatic events. Clerical 12 Hardware Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Lee Rupprecht ပ Thomas William McGinn, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Thomas W. McGinn, Sr. 108 Strathdon Way, Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 8/12/2008 Baltimore, Maryland 21. Signal Funeral Scaling puee

Martin D. Lawson Name and Address of Facility FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY **Physician** EMBOLISM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ed by the a detached f P.O. 1 Ves 2 No 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy page performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this After thi funeral of 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after dealt To the Funeral Director completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Hospital

State Registrar 31. Date filed (Month, Day, Year) 2008

Leonard Richardson,

29b. Signature and title of certifi



M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

マタフフィン

29d. Date signed (Month, Day, Year)

AUGUST

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11, August 2008 12:45 A<sup>M</sup> LEVI HORACE MANCHESTER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER Baltimore County Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 11 M 2□ F Months Days Hours Min 91 026-01-7504 **Director** Aug 2, 1917 Rhode Island Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ite Medical Exprimer runst to rediffed at Director 1 ☐ Yes 2 ☑ No Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 West Joppa Road Funeral 21204 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>م</u> Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than 'any injury or other traumatic event, Item any injury or other traumatic event, Item Manginge. Elementary/Secondary (0-12) College (1-4or 5+) Adminstrative Chief Engineer Telecommunications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Roland Lawton Manchester Ursella Almv ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jeffra M. Zeller 643 Piccadilly Road, Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Dulaney Valley M. Grdns 8/15/2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pyrer Service Systems Nartin D. Lawson MINCHELL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PLETASTATIC PROSTATE 48ARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 I Inknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 3 No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 Yes 2 Dolo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated To the within 2 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

Registrar

State

30. Name and address of person

31. Date filed (Month, Day,

Year,

6565

inpleted cause of death (Item 23a) (Type, Print)

32#Registrar's Signature

DOBERMAN, MO

164395

NEMARLES SUITE 209

AUGUST 11, 2008

BALTIMORE, MD 21204

			For State	State of	Marylan		ertment of F			jiene eg. No. 20	nα	25833
	Dh ! -!	6	1. Decedent's Name (First, Middle, La		Λ	1	lilicate of t	Dealli	2. Date of Deat		Year	3. Time of Death
	Physicia /Medic	al	Bunal		Dunale	1	Ab City Town o	L castion of Doot	9		10	1230 PM
	Examin	er	4a. Facility Name (If not institution, giv Seasons Hospice 8		,	ire	Randall	Location of Deat stown	n	Baltin		
	Funeral Director		5. Social Security Number 6. S 214-30-2459	ex SgtM 2□F	7. Age (In yrs. I	ast birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Jan. 24	(Year)	9. Birthp Cour	place (State or Foreign ntry) DC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	a-f sho	ctor	MD Anne Arı	ındel	Lau	ırel						1 □Yes 2 <b>/□X</b> No
	with the	Director	10e. Street and Number 301 Old Line Aver	1110			10f. Zip Code 20724		1	0g. Citizen of W USA	hat Cour	ntry?
	2 should be filed within 72 hours after death with the Maryland and Memberla 19ther is and Memberla 19ther is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Pedical Examination is to notified at	Funeral	11. Marital Status		dent Ever in U.S	S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race	- Americ	can Indian, etc.
	urs afte al", or it Examin	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes If Yes, Giv Year or Da	e		1 □Yes 2 ⊠ No	Specify:		Specify:		
	"natur	leted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind of Bu	siness/In	dustry
1	d withir giene. er than	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	Electi		a)		Electr	cal	
2	be file ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Last, Earl Anthony Ma						me (First, Middle, I Allen D		e)	
a y	should and Me s mark umatic	T <sub>0</sub>	19a. Informant's Name/Relationship (			19b. Mailir	ng Address (Street				State, Zip	Code)
2	1 and 2 Health a em 27 is		Mary Frances MacI	Donald/			old Line				0	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy figury or other traumatic event, the Profiled Examiner must be notified at once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special		state i		sition ( <i>Name</i> of natory or other place) In Cem.	Aug	Date . 9 , 08	20c. Location - 0		
	permit. Departr Importa any Inju		21. Signature of Funeral Service Licer	isee	M0105		2. Name and Addre	ss of Facility Do	naldson			e, P.A.
			23a Part1. Enter the disease, or com- shock, or heart failure. List only	plications that ca	aused the death		L3 Talbot er the mode of dyir				/	Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a hlad	dercar							Onset and Death
	Examiner		Composition list and disease	Due to (	or as a consequ	uence of):						
7	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a consequ	uence of):						4-4-4
5	cate be executed physician and the burial-transit	Exar	that initiated events resulting in death) Last	cDue to (	or as a consequ	uence of):						
		dical	•	d								
	The Hospital or Attending Physician: The law requires that the death certific within 24 hours after death, within 24 hours after death, or the Funear Birector: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	/sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 Fetal nant at time of d	Ideath 3	Ectopic pregnance Other (specify)	у		23d. Date Mor		ery Day Year
	w requires that the de been signed by the should be detached	by Phys	Part II. Other significant conditions	contributing to de	eath but not resu	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contr	ibute to t	he cause of death?
Š	require		- histori	y tunsi	llor Lai	nev			1 🗆 Y	es 2 No	3 ☐ Pro	bably Unknown
מון וועכ	n: The law icate has b r, page 2 sl	Completed							24a. Was a autop: perfor 1 □Yes	med?. d	Vere auto rior to co eath? Yes	opsy findings available empletion of cause of 2 No
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2	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page						h occurred at the ti	me date and place			nner as	hateta
	the Hos tin 24 h the Fun tpletely	Medical	750	miner: On the ba			ivestigation, in my					
<b>)</b>	70 With	2	29b. Signature and title of certifier		- NO		29c. Licens	66690	1	29d. Date signed	(Month,	Day, Year)
	20		30. Name and address of person who	completed caus	e of death (Item	1 23a) (Type,			1 hun 1	MPZIRL	,	
	Sta Registr		31. Date filed (Months Gay, Year)	2008 32.	egistrar's S <del>igna</del>	ture	pasts 1	10013101	1100011	. 5,0		
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08-06038

Heather Shirley Morrison

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 25834

Post can be control to the control t			I- For State Registrar				C	ertific	ate of	Death				F	Reg. No.			
Section Section Number   Section Section   Section Section   Section Section Number   Section Number   Section Section Number   Secti		n/	1. Decedent's Nam		st, Middle,Last)  Shirley  Morrison  2. Date of Death  Month Day Year August 7, 2008													
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Immediate Cause (Final disease or condition resulting in death)   Death	ືhysician						caused the de	eath. Do n	ot enter th	e mode of	dying, s	uch as ca	rdiac or r	espiratory a	rrest, sh	ock, or hea	art	Approximate Interval
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25. Was case referred to medical examiner?  1	Bo he deal the al	hys							:- 4b			uen in De	-+ 1	23a Dic	1 tobacco	o use contri	ihute to	the cause of death?
25. Was case referred to medical examiner?  1	P.O.	þ	Part II. Other sign	inicant cond	ILIONS C	onthouting	to death but i	not resulti	ng in the t	indertying	ause y	veninra			-			
25. Was case referred to medical examiner?  1	ds, equire een sig ould b	eted																
25. Was case referred to medical examiner?  1	e law r e has t ge 2 sh	mp											-	pe	rformed?	? .	leath?	
Natural   1			25. Was case refe	erred to medic	al		-			2	6.Place	of Death (	Check or		5 2	110	<b>V</b>	es 2 10
Natural   1	Vita nysicia this cel	0	1	2 No	Hos	pital: 1	Inpatient 2	ER/0	Outpatient	3 DC	)A	Other 4	Nursing	Home 5	Resid	dence 6	Othe	r. Scene
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  August 8, 2008  30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	n of ing Pl After funera					28a. Dat (Mon	e of Injury th, Day,Year)	28b	. Time of I	njury 28		-			e how in	njury occurr	ed	
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  August 8, 2008  30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Divi	ertifi				1					onice be	andrig, et	H	Halet	State)	3179 e, DM	Shi	loh Ct.
29b. Signature and title of certifier  O.C.M.E.  August 8, 2008  30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			29a. Certifier	Certifying	Physician	: To the be	est of my kno	wledge, d	eath occur	red at the	ime, da	te and pla	ce, and c	lue to the ca	ause(s) a	and manner	r as sta	ted.
O.C.M.E. August 8, 2008  30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To the within To the compl	edic			a	n the basis nd manner	of examinati stated.	ion and/or	investigat				curred at	the time, da				
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Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	_ /		1 aprill	( ) (HL	thell	MA_	Juse of death	(Item 230	)		J. J. II					3-0.0,		
State 31. Date filed (Month) Prox Year) 2008 32. Registrar's Signature	KO									1 Penn	Street	, Baltim	ore, M	D 21201				
Registrar AUG 1 % 2000 Page 10 April 10			31. Date filed (Mo	AUG Y	2 20	08 <sup>32. F</sup>	Registrar's Si		A.	weed .								

			1- State of Maryland / Dep. State of Maryland / Dep. Per dr., 9882,08/1	artment of Health and N 2/08dhb rtfficate of Death	Mental Hygi	ene g. No.2008 25836
	Physici /Medi		Decedent's Name (First, Middle, Last)  JAMES EARNEST MORTON		2. Date of Death Month JULY	Day Year 3. Time of Death 30, 2008 10:38 A
1	Examir		4a. Facility Name (If not institution, give street and number)  HARBOR HOSPITAL	4b. City, Town, or Location of Death  BALTIMORE		4c. County of Death
	Funeral Director		5. Social Security Number  212-36-9561  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 66  Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	
	Maryland a-f show ified at	ctor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ⊠Yes 2 ⊟No
	with the	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Country?
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the Maryland is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Event and the redthed at	d by Funeral	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	21225 Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto		USA  14. Race - American Indian, Black, White, etc.  Specify: BLACK
21215-0036	filed within 72 Hygiene.  Hygiene.  Sther than "natent, Inc. Medic	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired) SORER	ing 16	6b. Kind of Business/Industry  CONSTRUCTION
pu	be filed Ital Hyg Id othe event,	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	
ryla	2 should be and Mental is marked aumatic ev	은	HERBERT MORTON  19a. Informant's Name/Relationship (Type. Print)  19b. Mailir	MARY MC		City or Town State Zin Code)
e, M	permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trai		LORENE MORTON  20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  20b. Place of Dispocemetery, crem	1 SPELLMAN RD., B sition (Name of natory or other place)	ALTIMORE 20	, MD 21225 Dc. Location - City or Town, State 712 O DONNELL ST.
Balti	permit. Departm Importa any inju		21. Signature of Euneral Service Licensee 22	Name and Address of Facility WES 2007-09 EASTERN A	LEY CHAVI VE., BALI	TIMORE, MD 21231
E	hysician and bhysician and bhysician and bhysician and the privile transit the privile transit the privile transit the privile transit the privile transit the privile transit the privile transit tra	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or night) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		or respiratory arres	st, Approximate Interval Between Onset and Death
O. Box 6	y the attending p	Physician/Mec		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P.	s been signed by the s should be detached to		Part II. <b>Other significant conditions</b> contributing to death but not resulting in the un	nderlying cause given in Part I.		cco use contribute to the cause of death?
		Completed by			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  2No 1 Yes 2 DNo
Vital	s certifi	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatien	Other	(Check only one)	
Division of	affer death.  Director: After this certification by the funeral director,	ation: To	27. Manner of Death  1 ★ Natural 5 Pending (Month, Day, Year)  2 Accident Accident 28a. Date of Injury (Month, Day, Year)	4 Nursing Ho	me 5 ☐ Residence 28d. Describe how	ce 6 □Other (Specify) injury occurred
DIVIS	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, streeth building, etc. (Specify)		City or Town,	,
Hoe	n 24 hou	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death and manner stated.	continuation in managinian double account	and he alone alone and the second	
P of	Mithii Omp	Me	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month, Day, Year)
1	12)		30. Name and address of person who completed cause of death (Item 23a) (Type, I	H0006499	0 4	tugust 5,2008
1	5		29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Item 23a). Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Hanoverst, Bo	altimor	re MD 21225
	Star Registra	.6	AUG 1 2 2008			

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) 2008

VENKATA



MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0066357

80 PUA

2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	-		rtment of H <i>tificate of L</i>		d Me		jiene eg. No.	2008	258	38
	Physici /Medic		1. Decedent's Name (First, Middle, John Irvin Newton	Last)						Date of Deat Month	Day	2008	3. Time of Dea 7:31 a.	ath M
Ser. A	Examin	er	4a. Facility Name (If not institution, Stella Maris Hospi 5. Social Security Number	ce	(In yrs. last birth	nday)	4b. City, Town, or  Timonium  If Under 1 Year	Location of De	eath		E	County of Death	place (State or Fo	reign
	Funeral Director		229-38-5732 Usual Residence of Decedent	1 <b>∑</b> M 2□ F	72 <sup>Y</sup>	rs.	Months Days		lin.	Date of Birth (Month, Day, 31–193		Cou	vA	
	r 28a-f show	irector	MD Baltimo		10c. City, Town		stown 10f. Zip Code	-		1	Og. Citiz	zen of What Cou	10d. Inside City Li 1 □ Yes 2 X ntry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffied at once.	by Funeral Director	3903 Limo Road  11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Giver -		If	21133 /as Decedent of Hi Yes, specify Cuba  □Yes 2√√No	spanic Origin? n, Mexican, Pu <i>Sp</i> ec <i>ify:</i>	(Specif erto Ric	y Yes or No- an, etc.)	1	USA 14. Race - Ameri Black, White, Specify: Afri		an:
21215-0036	s within 72 hour sjiene. r than "natural the Medical Extrements of the	Completed I	15. Decedent (Specify only highes) Elementary/Secondary (0-12)	Year or Dates: s Education grade completed) College (1-4or 5+	, (	Give k life. D	ent's Usual Occupa ind of work done d O NOT use retired, Priver	luring most of i	working			nd of Business/Ir		
Maryland ?	ruld be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, L Daniel Newton	ast)	<b>\</b>			18. Mother's N			Maiden S	Surname)		
, Mar	and 2 sho ealth and m 27 is me her traums		19a. Informant's Name/Relationsh Clara Newton/Wife	ip (Type. Print)	390	O3 I	umo Road,	Randalls				r Town, State, Zi	p Code)	
Baltimore,	it. Pages 1 rtment of H rtant: If iter njury or otl	8	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp	ecify)	1	bpe	ition (Name of atory or other place Baptist ()	nurch 8-1			Calla	cation - City or T		
Ba	perm Depa Impo any i		21. Sign who if Funeral Service L	M. We	/// Do no	92	Name and Addres  O Liberty  The mode of dying	Road, Rai	rdall	stown, N	1D 21		Balto. Co.  Approximate	
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last	a. BLADD  Due to (or as a b. Due to (or as a c.	ER CANCI consequence of consequence of	): ):							Interval Betwee Onset and Deat	th
O. Box (	the death certific y the attending p ched for use as i	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	Fetal death		Ectopic pregnancy Other (specify)	,			2	23d. Date of delive Month	rery Day Year	,
ords, P.	w requires that the de been signed by the s should be detached f	þ	Part II. Other significant condition	ns contributing to death but	not resulting in t	the und	derlying cause give	n in Part I.					the cause of death	
al Reco	n: The law rificate has be r, page 2 sh	Completed							_	24a. Was a autops perforr 1 □ Yes	ned?	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings avai ompletion of cause 2 □No	lable e of
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certivithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	ation: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day,	nt 2 □ ER/Outp / /Year) 28b. Tir Inj		28c. Injury Work	4 LI Nursin	g Home		ence 6		fy)HOSPICE	<u> </u>
Divis	ital or Attencrs after death al Director; led in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, farn (Specify)	n, stre	et, factory, office		28f.	Location (St City or Town	treet and n, State)	d Number or Rur	al Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  1 Certifying 2 Medical E	Physician: To the best of xaminer: On the basis of and manner stat	examination and	death for inve	estigation, in my or	oinion, death o	ace, and ccurred	at the time, d	ate and	place, and due t	o the cause(s)	
	A 18 60	_	Fine	ho completed cause of de	ath (Item 233) (T	VICE	29c. License	527	40		H. H	e signed (Month,	11 m 700	8
	Sta Registr		DR. ERNESTINE W 31. Date filed (Month, Day, Year)		1		LLEY RD.	TIMON	IIUM,	, MD 2	1093			-

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AUGUST 11, 2008

JOHN NEWTON

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H			giene Reg. No. 2008	3 25839
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Year	3. Time of Death
	/Medic Examir	cal	Robert L. O'Haver	treet and number)		4b. City, Town, or		Pugust	4c. County of Deat	
di <sup>e</sup>	Funeral Director		Julia Manor Nursi 5. Social Security Number 6. Sex 218-44-5576		(In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days		lin. 8. Date of Birl (Month, Da Oct 28	Washington  Washington  Washington  Washington  Washington  Washington  Washington	thplace (State or Foreign buntry) th Carolina
	faryland f show	ō	Usual Residence of Decedent  10a. State 10b. County  MD Washingto		10c. City, Town or Lo Hagers					10d. Inside City Limits 1 □ Yes 25 □ No
	or 28a-	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Co	**
-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, It's Madical Examinar must be notified at	by Funeral	1 □ Never Married 2 □ Married 3 □ Widowed 4 🔯 Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:	(Specify Yes or No lerto Rican, etc.)	Specify: W	hite
21215	d within 72 giene. er than "na'	Completed	15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12) 12 3	completed) College (1-4or 5+	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of t	working	16b. Kind of Business/	industry
and	d be file ental Hy ked othe c event	Be	17. Father's Name (First, Middle, Last)  Mcarthur Lewiston	n O'Haver				Name <i>(First, Middle,</i> L'hurston	Maiden Surname)	
lary	Z shoul n and Mi 'Is marl raumati	70	19a. Informant's Name/Relationship (Typ	e. Print)			and Number or	Rural Route Number	er, City or Town, State, 2	Zip Code)
	Pages 1 and 2 should been of Health and Mentinit: If Item 27 Is market iry or other traumatice		Daniel O'Haver/bro  20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		P.O.  20b. Place of Dispo	Box 252 sition (Name of natory or other place		Date VA	22656 20c. Location - City or	Town, State
Balti	permit. Pages I Department of H Important: If Ite any injury or ot once.		21. Signature de le rational de la r	ade Dire		Name and Addrestate Anal	_		. Baltimore	Street
4	Chysician be executed for the private personned for the private transit transi	al Examiner	23a. Part L. Enter the disease or complete shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	he death. Do not ent	er the mode of dyin	ng, such as card	diac or respiratory a	obstruct	Approximate Interval Between Onset and Death
ñ į	attending for use a	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	ic. If yes, outcome o  1  Live birth 2  4  Pregnant at t 9  Unknown	Fetal death 3	Ectopic pregnance	у		23d. Date of de Month	livery Day Ye ar
Records, P.	sician: The law requires that the or certificate has been signed by the rector, page 2 should be detached	þ	Part II. Other significant conditions cont	ributing to death but	not resulting in the u		en in Part I.		obacco use contribute to Yes 2 ☐ No 3 ☐ P	
ပ္မ	n: The law rificate has be r, page 2 sh	Completed			Spinal	Tura	r_ <b>~</b> ~	24a. Was autop perfo 1 □ Yes	prior to death?	utopsy findings available completion of cause of
or Vital	nysicial his certi I directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 Nie	ospital: 1 ☐ Inpaticn	t 2 ER/Outpatier	nt 3 DOA Othe		Death <i>(Check only o</i>	one) dence 6 □Other (Spe	ecify)
DIVISION O	To the negation of substants the figure of the forms and the death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day,	Year) Injury	M 1 🗆		28d. Describe	how injury occurred	
2	urs after rral Direction by		4 ☐ Homicide determined		y - At home, farm, str (Specify)			City or Tov		
	in 24 ho he Fune pletely f	Medical	29a. Certifier 1 ☐ Certifying Physic (Check only one)	ician: To the best of er: On the basis of and manner state	examination and/or in	n occurred at the tir vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the ccurred at the time,	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
	with To t	M	29b. Signature and title of certifier	ulul		29c. License	e number	96	29d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who con	npleted cause of dea	th (Item 23a) (Type, HED	Print)	26	opal	CT.	21740
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2 201	32. Registrar	's Signature		3	- 1-	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 10,2008 Month AUGUST **Physician** 7:30A Douglas Arthur Pooley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Saint Joseph Medical Center Towson 8. Date of Birth JAN 9 1930 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Massachusetts 78 013-22-0257 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is merked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaluation must be notified at 1 ☐ Yes 2 No Funeral Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21228 USA 32 Delrey Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Defense Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h Edith Garfield Harold Α. Pooley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health 32 Delrey Avenue, Catonsville, Maryland Alison J. Pooley - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory, Inc.; 8/11/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Stievense H. Williams 22. Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HYPOVOLEMIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HYPOALBUMINEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit CHRONIC RENAL FAILURE Division of Vital Records, P.O. Box 68760公 Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE 2 No 3 Probably 4 Unknown 1 🗌 Yes GENERAL DEBILITY 24b. Were autopsy findings available prior to completion of cause of death? certificete has birector, page 2 s autopsy performe 1 ☐ Yes 2 No 2 🗆 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐Yes 2 ☐No 2 Accident investigation ours after death nerel Director: / filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 68 37254 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON. MARYLAND POH 1 31. Date filed (Month, Day, Year) IM M D 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelibie Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year Physician 10:21 A M 9 2008 Aua /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Balhmore ST Agnes Hospital If Under 1 Year | If Under 24 Hrs. ial Security Number Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Hours 215-52-212 Months Days 1□ M 2**X**F 60 Yrs SUPI Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 28a-f show Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Exa<u>miner must be notified at</u> 1 Yes 2 No more Director 10f. Zip Code 10g. Citizen of What Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Decedent Ever in U.S. Black, White, etc. ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life po NOT use reyfed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) ner's Name (First Middle 2 should be fi Be nber or Rural Route Number, City or Town, State, Zip Code) band 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of h ∠ □ Cremation 3 ☐Removal from State 5 Other (Specify) ignature Ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. mmediate Cause (Final Physician Preumonia day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cancel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a con el uence of) Examiner certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery lor 3 ☐ Ectopic pregnancy Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2□ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∐ Yes Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifice funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes · 2☐ No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred atural 5 ☐ Pending investigation 2 ☐ Accident 2 □ No 1 🔲 Yes filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P 20965 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BODDU. ST AUNES 1+OSPITAL, 900 SCATON AVENUE, BALTIMORE 32. Registrar's Signature 31. Date filed (Month, Year) State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20a-c-22 per FH G882 8/25/08 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 12:10 PM 2008 Ricki Price August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral S Months Days Hours Min 1**X** M 2□ F 52 Yrs Oct 6, 1955 Washington DC Director <u>577-74-0623</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examinar mast be notified at Director 1 ☐ Yes 2√☐ No MD Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Stuart Lane 20735 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2X No black Specify: <u>≽</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other traumatic aux." Elementary/Secondary (0-12) College (1-4or 5+) disabled none 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be William Leo Price Dimples Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Abney/friend 1612 Savannah Street SE #104 Washington, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 3 X State (Specify) in State in stat Washington National 8-19-08 Suitland, Md. 22. Name and Address of Facility Capital Mortuary 1425 Maryland Ave S. Wale, Director Ronald MD 21201 Washington, Dc. 20002 Baltimore, Enter the disease, or committee the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

ause (Final Cardition 23a. Part Approximate Interval Between Onset and Death Immediate ause (Final disease or c dition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ۵ Disease on Hemochil 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should b Completed (mmuno 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **T**No 1 □Yes 2 ☑No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 005500 Name and address of person who completed cause of death (Item 23a) (Type, Print) warhenglon De 20032 Hickord Pahne 1328 Sentrem avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

ORIGINAL

08-06040 Shannon Lynne Powell

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 25843

	•		For State Certificate O	f Death	Reg.	No.	
	Physicia   Exami	in/	1. Decedent's Name (First, Middle,Last)	vell	2. Date of Death Month D August 7, 20	ay Year	3. Time of Death 1640 hrs
	LXami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	n
			723 Lewis Street  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Havre de Grace  If Under 1 Year   If Under 24Hrs	8. Date of Birth(	Harford  MM/DD/YYYY) 9. Bit	rthplace (State or
	Funeral Director		218-43-5479 1 M 2XF 28 YM	Months Days Hours Min	<b>-</b>	Forei	
	any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	tion	(_)		10d. Inside City Limits
	<b>*</b>	٥	MA Harford H		ace		1 Yes 2 No
100	MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho umatte event, the Medical Examiner must be notified at once	Dire	10e. Street and Number 723 Lewis Street	10f. Zip Code 21078	10g.	Citizen of What Cou	intry?
126	death with rritens 23 nust be no	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		White, etc.	rican Indian, Black,
	s after iral", c	ĝ	or Dates:	Yes 2 No specify:	work done 1	Specify: 6b. Kind of Business	/Industry
	72 hour n "natı al Exar	eted		most of working life. DO NOT use ret		/.	
	5-0036 led within 7 Hygiene. I other than	ompleted	the state of the s	odent	e (First, Middle, Ma	N/H	
	ID 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than 'natic event, the Medical	Be	17. Father's Name (First, Middle, Last) Howard F. Van Gilder	Lun	n Hon	ne	
	D 21 should and Me 7 is ma	10	11 (14 )	ng Address (Street and Nymber or Philadelphia			1040 21040
	ra lt md	- III		osition (Name of cemetery,	Date	20c. Location - City o	or Town, State
	Baltimore, permit. Pages 1 a Department of He Important: If it injury or other 1		A Describe 5 Other Specific	18 200m 300m	16/08	Forest +	611, MD
	Baltimo permit. Page Department o Important: injury or otl		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility	Pet	, Foost	HII MO 2013
	hysician	177	23a. Part I. Enter the disease, o complications that caused the death. Do not enter	ans Func not Char the mode of dying, such as cardiac	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
	Medical Examiner		failure. List only one callse on each line.  Immediate Cause ( <del>Pinal di</del> sease a. <b>Narcotic intoxicati</b>	<del>on</del> Cardiac arrhy	thmia		Death
	LAMITTE		or condition resulting in death)  Due to (or as a consequence of):  Left ventricular di	latation			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
		Examiner	(Disease or injury that initiated events resulting in death) Last				
	760, icate be executed physician and the burial - transit	alE	d. <b>V</b>	perMF (882 8/18	/ሰዩ ጥጥ		
	760, icate be executed physician and the burial - trans	Medical	IF FEMALE:    X   AMENDED   23a , 27 , 28a-f , PI   23a-b , 27 , 28a-f , 28a-f , 27 , 28a-f , 27 , 28a-f , 27 , 28a-f , 27 , 28a-f , 27 , 28a-f , 28a-f , 27 , 28a-f ,	8a-f, per ME G88	5 11725/	08 TT	өгу
	6876 certificat nding ph se as the	an/N	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr	nancy	Month	Day Year
	Box 687 e death certific the attending	ysician	4 Pregnant at time of death 5 Unknown 9 Unknown	Other (Specify)			
	Division of Vital Records, P.O. Box 68: the Hospital or Attending Physician: The law requires that the death certifithe Function after death. The Function of the Function: After this certificate has been signed by the attending replacely filled in by the functal director, page 2 should be detached for use as it.	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			to the cause of death?
	ords, P w requires t s been sign should be	ted t			-   24a. Was a	n   24b. Were	autopsy findings available
	Division of Vital Records, rater are are are are are are are are are a	Completed			autops perform 1 <b>V</b> Yes 2	ned? death	
	tal Reciding The laterate laterate la rector, page	e Co	25. Was case referred to medical	26.Place of Death (Chec		10	Tes 2 NO
	Vita hysicia this cer	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		S Lamid	Residence 6 🗸 Ot	her: Scene
	ding Ph	on:	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day,Year)  28b. Time of Death (Month, Day,Year)	of Injury 28c. Injury at Work?	unk	ow injury occurred	
	r Atten er deatl rector	ficati	2 Accident Investigation X 28e, Place of Injury - At home, farm, st	AND THE PARTY OF T			Rural Route Number, City
-	Div pital or ours aft eral Di	Certification:	3 Suicide 6 Could not be determined (Specify) Home		or Town, St	ate)	re de Orice,
P	To the Hospital or / within 24 hours after To the Funeral Dire		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc one) Wedical Examiner: On the basis of examination and/or investi	curred at the time, date and place, at gation, in my opinion, death occurrer	nd due to the cause d at the time, date a	e(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within 2 To the complet	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (i	
			( Cantal one)	O.C.M.E.		August 8, 2008	3
	7		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 21	1201		
U		tate	31. Date filed (Month, Day Year) 2. Registrar's Signature	while			
	Regis			40000			

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			For State	State of Maryla				-	_	0000	05011
	_		Registrar  1. Decedent's Name (First, Middle, La.	st)	Cei	rtificate of l	Jeain	2. Date of De	Reg. No.	2008	25841
	Physicia		LAWRENCE	PALUSKIEVI	CZ			Month	Day	Year	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	HAUGUST		County of Death	10.30 11
3		V. 9	7613 Cypress Ave	enue		Balt	imore Co	•		Baltimo	ore Co.
	Funeral		Social Security Number     6. S	Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	v. Year)	Coul	place (State or Foreign
L	Director		212-32-3443	72	Yrs.			Oct. 2	1,19	35 Penr	nsylvania
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mary -f sho	tor	Maryland Balt	imore		B	altimore	Co.			1 □Yes 🎞 No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		7613 Cypress A	venue			21224		Uni	ted Stat	tes
	ems er mu	Funeral	11. Marital Status	12. Was Decedent Ever in 1 Armed Forces?	J.S. 13.	Was Decedent of H	ispanic Origin? (	Specify Yes or No	- 1	4. Race - Americ Black, White,	
20	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give		1 □ Yes 2 ☒ No	Specify:			Specify:	
2-0036	hour tural		15. Decedent's Ed	Year or Dates: 1954		dent's Usual Occup	ation			d of Business/in	White
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and	al Hygie I other vent, th	Be C	17. Father's Name (First, Middle, Last,	<b>'</b>				me (First, Middle			
<u>X</u>	Ment Ment arked atic e	To	Stanley F. Pa	luskievicz			Adr	ian Fitz	patr	ick	
nar	es 1 and 2 should be fi of Health and Mental F f Item 27 Is marked otl ir other traumatic ever		19a. Informant's Name/Relationship ( Lori Ann Souders		19b. Mailir 7624	ng Address (Street a		lural Route Numb Baltimore			Code) 21224
e)	is 1 and 2 of Health a item 27 is other trai		20a. Method of Disposition			sition (Name of	Ave. I	Date			
more,	ages nt of t: If It		1 ☐ Burial 2 【A Cremation 3 ☐	Demouel from State	cemetery, crer	matory or other place Service Co				ation - City or To 1 t i more	, Maryland
Saitill	permit. Pages 1 Department of H Important: If ite any injury or ot		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	**							-
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ŀ	4		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	ath. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
61	Physician		Immediate Cause (Final disease or condition	· COLONI G	LIVER						Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	quence of):						15 MONTHS
	Examiner	_	Sequentially list conditions,	b							
7	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):						
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go	leath certifi attending for use as	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		2	3d. Date of deliv	ery
о Б	the death cert y the attending iched for use a	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)				Month	Day Year
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	siclan: The law r certificate has be irector, page 2 sh	Completed	FAILURE					24a. Was auto	an psy ormed?	prior to co death?	opsy findings available impletion of cause of
VITAI H			25. Was case referred to medical				OG Diago of Da	1□ Yes	2 <b>2</b> No	1 ☐ Yes	2 No
	Physiclan: r this certific ral director,	To Be	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2[	☐ ER/Outpatier	nt 3 DDA Oth	or:	eath <i>(Check only o</i> Home 5 Resi		□Other (Speci	(f <sub>V</sub> )
0	Jing Phys 1. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe			
0	endlr sath. or: At	atic	2 Accident investigation	n			Yes 2 □ No				
UIVISION	or Att fler de Sirect in by 1	Certification:	3 Suicide 6 Could not be 4 Homicide determined			eet, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Run	al Route Number,
	pltal		29a. Certifier 17 Certifying Pt	nysiclan: To the best of my kr	owledge doat	h occurred at the tir	no data and plac	o and due to the	221122(2)		
	24 hc 24 hc e Fun letely	Medical	(Check only 2 Medical Examone)	miner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, death oc	curred at the time,	date and	place, and due t	stated. to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	, 1		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	1,1		James 1	Landin 1	UD	NG	2032			8-7.	2008
	MY		30. Name and address of person who	completed cause of death (Ite	, , , , ,	Print)					
	IV		JENNIFER HAYAS		UNS BM	WEW CI	RCLE	BALTIA	10RE	EMD	21224
	Sta Registr		31. Date filed (Month, Day, Year)	. Hegistrar's Sigi	nature						,
DΠ	MH 17 Rev 1/2	4	AUG 1 2 200	18 filestyse S	- Parties	A ST					

			For State Registrar	State of Mar		artment of F <i>rtificate of I</i>		Mental Hy	rgiene Reg. No. 20	08 2584	1 5
	Physici: /Medic		1. Decedent's Name (First, Middle, Last)  James Bret Peep	Les				2. Date of De August	ath Day 2008	Year 3. Time of Deat 10:42A.	
	Examin	er	4a. Facility Name (If not institution, give s Union Memorial I			4b. City, Town, or Baltin			4c. County o	of Death	
	Funeral Director		214-00-7030	M 2□ F 7. Age 48	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of Bi (Month, D Aug. 1	4, 1959	9. Birthplace (State or For Country) Maryland	reign
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A	1	Oc. City, Town or Lo					10d. Inside City Lir <b>XX</b> Yes 2 □	
	h with the	Funeral Director	10e. Street and Number 3139 Keswick Road	1		10f. Zip Code	21211		10g. Citizen of W	hat Country? USA	
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventinal must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Divorced	2. Was Decedent Ev Armed Forces? 1 ∐Yes 2∰No If Yes, Give Year or Dates:	}	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □ No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	14. Race Black Specify:	- American Indian, k, White, etc. White	
Baltimore, Maryland 21215-0036	filed within 72 h Hyglene. other than "natu ent, Ire welle	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	ation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired a Entry	during most of w	orking	State o	siness/Industry f Maryland	
yland	2 should be filed w n and Mental Hygie is marked other t raumatic event, In	To Be (	17. Father's Name (First, Middle, Last) Gilbert Peeples	•			Mary L	utz	e, Maiden Surname	,	
e, Mar	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Type Elizabeth Lutz	e. Print) Aunt			oft Roa		more, Ma	ryland 21239	
timore	Pa Int:		20a. Method of Disposition  **DESTRUCTION   2 □ Cremation   3 □ Real   3 □ Cremation   3 □ Real   3 □ Cremation   3 □ Real   3 □ Cremation   3 □ Cremation   3 □ Cremation   3 □ Cremation   3 □ Crematical   3 □		City or Town, State  t City, MD						
Bal	permit. Pa Departmer Important any Injury		21. Signature of Juneral Service License	Hens	$4)$ $\frac{1}{3}$	2. Name and Addre Burgee—Her 631 Falls	nss-Seit Road,	Baltimo	re, Mary	lan <u>d</u>	
	ificate be executed  Examiner  By physician and  By the burial-transit  By the burial-trans	edical Examiner	23a. Part 1. Energy the disease, or complice shock, or eart failure. List only one immediate Cause (Final disease or condition resulting in death)  Securatively later and the fair and leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):		ng, such as cardi		arrest,	Approximate Interval Between Onset and Death	1
O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date Mor	e of delivery hth Day Year	
ords, P.	w requires that s been signed b should be deta	þ	Part II. Other significant conditions con-	ributing to death but	not resulting in the u	inderlying cause giv	en in Part I.			ibute to the cause of death	
		e Completed	25. Was case referred to medical				26 Place of D	24a. Was auto perfi 1 □ Yes	ppsy ormed? d 2 VNo 1	Vere autopsy findings availi rior to completion of cause eath? ☐Yes 2 ☐No	able of
f Vi	nysical nis ce direc	To Be	examiner?	ospital:	2 R/Outpatie	nt 3 DOA	or:		idence 6 ☐ Othe	er (Specify)	
Division o	ding h. After funer	Certification:	27. Manner of Death  1 ☑Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day,	Year) Injury	M 1 🗆	yat k? Yes 2 □ No		how injury occurre		
Dİ	spital or Atteno ours after death eral Director: filled in by the f		4 Homicide determined	building, etc.	/ - At home, farm, sti (Specify)	теет, тастогу, опісе		City or To	(Street and Number wn, State)	er or Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only one)	ician: To the best of er: On the basis of e and manner state	examination and/or in	th occurred at the ti	me, date and pla opinion, death oc	ice, and due to the curred at the time	e cause(s) and ma , date and place, a	nner as stated. Ind due to the cause(s)	
	To 1 To 1	Σ	29b. Signature and title of certifier	· Dun	14/18	. 29c. Licens	e number	248	29d. Date signed	(Month, Day, Year)	
	5		30. Name and address of person who con	apleted cause of dea	ath (Item 23a) (Type	Print)	, 80	Balli	new;	w10,2121	11

DHMH 17 Rev 1/2001

State Registrar

Reg. No.2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** AUGUST 2008 7:38 PM HELEN MARY PHILLIPS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GILCHRIST HOSPICE BALTIMORE TOWSON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖫 F 220-03-6989 95 Director 22. 1913 FEB. MD Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director MD HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country items 23a or 1610 WATERBURY CT 21014 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ☑ No WHITE Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျ CASMIR BROCKI ELIZABETH ZAJACZKOWSKI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 1610 WATERBURY CT ELAINE LUTCHE-DAUGHTER BEL AIR, MD 21014 20b. Place of Disposition (Name of cernetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/9/08 HOLY REDEEMER CEM. BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR RD BALTIMORE, MD 21206 23a, Part 1. Enter the disasshock, or heart Approximate Interval Between Onset and Death and complete that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUBARACITADO **Physician** Weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Year Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 □ Yes ÀZ No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 5 Pending investigation eral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 6 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONSON M) 2,204 BARON J. CHARIES w 6701 N. harles ST 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 12 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State o	f Marylar	-			ealth a Death	ind Me	_	giene Reg. No	400	8	25847
	Physici	20	1. Decedent's Name (First, Middle, La.	st)						:	2. Date of De	ath Da	v )	/ear	3. Time of Death
	/Medic		Evelyn Margaret	Renner	·						August	09,	2008	3	4:10 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give		mber)				Location of	f Death			. County of		
			Riverview Care Ce 5. Social Security Number 6. S		7 6 //	to a black to 1	Ess	eX r 1 Year	If Under 2	24 Hrs.			Baltin		
L	Funeral Director			өх □м <b>¾</b> [2 <b>х</b> F	7. Age (In yrs. 8!	• •	Months		Hours	Min.	3. Date of Birt (Month, Da 08/31/	n 1918	3 1		lace (State or Foreign try) land
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	0d. Inside City Limits
	Mary fish	to	Maryland Baltimor	re	Es	sex									1 ☐ Yes XX No
	r 28g	irec	10e. Street and Number				10f. Zi	p Code				10g. Cit	tizen of Wh	at Coun	try?
	th wit	Funeral Directo	217 Oberle Avenue	•				21 221				τ	J.S.A.		
	r dea	ner	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spec , Puerto R	ify Yes or No ican, etc.)	-	14. Race - Black.	Americ White,	
2	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, Gi	ve	1	1 🗆 Yes				, ,		Specify:		
2-003a	hour tural	d be	Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or D	ates:	16a. Dece	dont's He	al Ossun	ntion			165 V	ind of Duci	Whi	
Ċ	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show int, the Medical Exact rectified at	Completed	(Specify only highest gra	de completed)		(Give	kind of wi	ark done o	turing most	of working	7	10D. N	ind of Busi	11622/11/	lustry
7	d with giene.	ШО	Elementary/Secondary (0-12)	College (	1-40r 5+)		make.					Owr	n Home	ح	
ğ	be file ital Hyg id othe evant,	3e C	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (	First, Middle,			-	
yland	should b ind Ments markad imatic e	To Be	Alexander William	son					Edna	Robi	nson				
Mar	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship (Barbara Holter (G		ighter)						Route Numbe				
ē,	permit. Pages 1 and Department of Healt Important: If itam 2 eny injury or other ODCS.		20a. Method of Disposition			Place of Dispo	sition (Na	me of	e)	Da	te	20c. L	ocation - Ci	ity or To	wn, State
Бант	Page nent o		1XDBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif			lly Hil				8/13/	2008	Ba]	Ltimo	re,	Maryland
a	permit. Departn Imports eny inju		21. Signature of Funeral Service Licer	1S88							Funer				
0	80 = 50		19/10			1	407	old i	Caster	rn Av	enue,	Esse	ex, Ma	aryl	and 21221
	Physician		23a. Pant Enter the disease, or com spock, or heart failure. List only Impediate Cause (Final disease or condition	plications that one cause on e		th. Do not ent	er the mo	de of dying	g, such as o	cardiac or	respiratory ar	rrest,			Approximate Interval Between Onset and Death
	/Medical Examiner		résulting in death)	Due to	(or as a conse	quence of):	AN	en	D	ises	ne				un-know
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	quence of):	-								
,00/	ate be executed thysician and the burial-transit	ical Exa	resulting in death) Last	Due to	(or as a conse	quence of):									
200	certificate Iding phys	edic		d											
J. BOX	e death certific the attending p ned for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live t	tcome of pregn pirth 2 Fet nant at time of own	al death 3 [	⊒Ectopic p ⊒ Other (s						23d. Date Month		ry Day Year
Ţ.	d by			contribution to d	anth hut not un	aultina in the co					00 - Dida				
ecords,	law requires that the death as been signed by the atter 2 should be detached for u	ed by	Part II. Other significant conditions of	omic 1	eath but not re	HF,		Cause give				res 2			e cause of death? ably 4 □Unknown
သ	law re as bea 2 sho	Completed									24a. Was		24b. We	ere auto	psy findings available
r	The ate has page	mo;									autop perfo	rmed?	dea	ath?	npletion of cause of 2□ No
VII	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?						26. Place	of Death	Check only o				
>   	Physic this ceral dire	2	1 Ves 2 No	Hospital: 1 🗆	Inpatient 2	ER/Outpatier	nt 3 🗆 D	OA Othe	or: 4 Nur	rsing Hom	e 5 Resid	dence	6 Other	(Specify	1)
	ong P	on:	27. Manner of Death 1 ☑ Natura! 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	f	28c. Injury Work	at ?	28	ld. Describe l	now inju	ry occurred	d	
<u> </u>	Attending or death. Rector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not b				М	1 🗆 `	Yes 2□N	No					
DIVISION	s after d el Diract ed in by	Certification:	4 Homicide determined	200. Place	of Injury - At hing, etc. (Spec	nome, farm, str ify)	eet, factor	ry, office		28	3f. Location (S City or Tov			o <i>r R</i> ura	l Route Number,
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer:	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exar	niner: On the b	best of my kn asis of examin ner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date and pinion, deat	d place, ar th occurred	d due to the d at the time,	cause(s date and	) and manr d place, an	ner as si d due to	ated. the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier				29	c. License	number	7 (	11.	29d. Da	ite signed (	Month,	Day, Year)
			ME	•				1)	38	15	4	08	-09-	- 08	2
	3		30. Name and address of person who MALIKA USA	completed caus		m 23a) (Type,	Print)	ZRN	BU	UD.	. ^	1 D	- 2	122	1.
	Sta Registr		31. Date filed (Month, Day, Year) AUG 12	2008 32. F	ggistrar's Sign		Cart	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harry Martin Ruth, III 2008 11:55 a <sup>™</sup> August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson 8. Date of Birth (Month, Day, Year April 28, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Year) 1931 Months Days Hours Min 1 ☑ M 2 ☐ F 213-28-5332 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 8 New Forest Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No 2 Specify: SpecifyUnite 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Business Forms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miriam Harry M. Ruth, Jr. Raver ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret M. Ruth/ Wife 8 New Forest Ct. Towson, Md. 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Co. 8-12-08 Towson. Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home, 21. Signature of Funeral Service Licensee 1050 York Rd. Towson, Md. 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SAVCOMA disease or condition resulting in death) ear Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Hospice 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Examiner requires that the death certificate be executed 68760. Records, Physiclan:

Attending

attending physician use as for À cate has been signed | page 2 should be deta certificate After this certific death. within 24 hours after deatl To the Funeral Director: filled in by ō Hospital

**Funeral** 

Director

death with the Maryland

1 and 2 should be filed within 72 hours after death with the Marylan Heatth and Mental Hygiene.
Heatth and Mental Hygiene.
To is marked other than "natural", or items 23a or 28a-f show ther 27 is marked other than "natural", or item must be notified at

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr

**Physician** 

/Medical

the burial-tran

Maryland 21215-0036

3altimore,

completely State Registrar

29b. Signature and title of certifier Bruc (>

investigation

determined

6 Could not be

wo

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Balto, ms 2,201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St.

6701 32. Registrar's Signature 31. Date filed (Month, Day, Year)

2008 AUG 1

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

8-06110 Eileen Marie Artley Rey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2008 25849

		or State			Certifica	te of	Deatn_			- 10		. No.	1	3. Time of Death
Physician		istrar Decedent's Name (First, Middle									Date of Death Month	Day Yea	1	1147 hrs
ical Examine		Eileen	Maile Michael Pacith							August 10,	4c. County	of Death		
β <b>4</b> 0,		Facility Name (if not institution	n, give street and i							Death		4c. County		
		University Hospital					Baltimo			- 41 -	0.00	h/MM/DD 2000	N/A	place (State or Foreign
Funeral	5. 9	Social Security Number	6. Sex	7. Age (In y	yrs. last birth	day)	If Under		If Under Hours	24Hrs. Min.			Cou	ntry)
Director		17-72-6371	1 M 2 X F		50	Yrs.	Months	Days	Hours	IVIII I.	07/1	8/1958	<u> </u>	DC
Director.	1 -		I IVI ZA				1							10d. Inside City Limits
		ual Residence of Decedent a. State 10b. County		10c.	City, Town o	or Location	on						į	
w any	Glen Burnie								- 1	1 Yes 2 X No				
and	1.0f Zip Code 10g. Citizen of W								/hat Coun	try?				
Maryland 28a-f show datonce.	[ 10   10	e. Street and Number							21060	2		1	USA	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene fant: If item 27 is marked other than "natural", or items 23a or 28a-f. sho or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner		1002 Nabbs Cre				40. 141=	- Danadan				ecify Yes or No			can Indian, Black,
with ns 23		. Marital Status	A = ma = c	Decedent Ever	r in U.S.	13. Wa	es, specify	Cuban,	Mexican,	Puerto F	Rican, etc.)	Wh	ite, etc.	
leath r iter	Š 1	Never Married 2 X M	1 Ye	s 2 X	No				onesit :			Specify	C TAT	hite
fler of	<b>⊸</b>   3		vorced If Yes, Give				Yes 2 nt's Usual C			and of w	ork done	16b. Kind of I		
urs a itura	ا ق	15. Decedent's Education (Spe			ted) 16a.	Deceden during m	nt's Usual C lost of work	ing life.	DO NOT	use retire	ed)			
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5-0036 iled within 7. Hygiene d other than	힏	12				F	Haird:	ress	er	l- Namo	/First Middle	Maiden Surnar	etolo	<u> </u>
d with	팃	7. Father's Name (First, Middle	e, Last)											
al Hy	Be	Harry A	rtley						Ru	th	Nas		our State	Zin Code)
2121 ould be fil Mental I marked ic event,	2 1	9a. Informant's Name/Relation										mber, City or T		
MD id 2 show that and m 27 is aumativ	-	Henry E. Rey	Jr. (	spouse	)					Roa		n Burni	e, MI	Town, State
and 2 and 2 ealth tem 2	2	0a. Method of Disposition			20b. Place	of Dispo	sition (Nan ther place)	ne of cer	metery,	Aug	Date 12	200. Localic	III - City of	Town, Diate
of H of H	- 1	1 Burial 2 X Crematic		al from State	Metro				nc.		8008	Balti	more	Maryland
Pag ment ment fant:		4 Donation 5 Other	Specify:	11	THECT									ome, P.A.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural".	2	1. Signature of Funeral Service	e vicensee	0//	11)							sadena,		
<b>a</b> % 2 = .= [		23a. Flart I. Enter the disease,	Lucel	XXX	oddath Dor	not enter	the mode	of dvina	such as	cardiac c	or respiratory a	rrest, shock, or	heart	Approximate Interval
Physician	2	23a. Hart I. Enter the disease, of failure. List only one cause	or complications to se on each line.	nat caused the		iot cintor	and more				,			Between Onset and Death
/Medical	- 1	Immediate Cause (Final diseas	se a. Multiple	Injuries									_	
aminer		or condition resulting in death)	Due to (or	as a consequ	uence of):									
		Sequentially list conditions,	b		. ()									
	ا <u>ه</u>	if any, leading to immediate cause. Enter Underlying Cause		r as a consequ	uence or).									
	Ē	(Disease or injury that initiated	Due to (e	r as a conseq	uence of):									
ed nsit	Ľ.	events resulting in death) Las	d d											
recuted n and - transit		UNPENDED	AMEN!	DED										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detacted for use as the burial. Transit	edical			ves, outcome	of prognant							23d. Da	te of deliv	ery
760, ficate be g physic sthe bur	≥	IF FEMALE: 23b. Was decedent pregnant in		Live birth	s of pregnant		Fetal death	1 3	Ecto	pic pregr	nancy	Mon	.th	Day Year
68 certif	iai	past 12 months?		Pregnant at ti	me of death	5	Other (Sp	ecify)						
Box 68 death certif the attending	sic	1 Yes 2 No 9 🗸	9	Unknown										to the source of death?
, P.O. Box 68. ires that the death certification signed by the attending to be detached for use as	Physiciar	Part II. Other significant cor	nditions contribu	iting to death	but not resul	ting in th	ne underlyir	ng cause	e given in	Part I.				to the cause of death?
P.O. es that the igned by the detaction	ρ										_   1 _			robably 4 Unknown
S, F uires n sign Id be	g										24a. W		24b. Were	autopsy findings available to completion of cause of
ords, w requir s been s should	흥										p	utopsy erformed?	death	1?
Division of Vital Records, tal or Attending Physician: The law requirer as after death.  To she death.  To brector: After this certificate has been silled in by the funeral director, page 2 should telled in by the funeral director, page 2 should telled in by the funeral director.	Completed										1 🗸 Y	es 2 No	1 🗸	Yes 2 No
Rec : The l ificate of, page		25. Was case referred to med	dical					26.Pla			ck only one)			
Vital F ysician: his certifi director,	Be	examiner?	Hospital:	1 / Inpatier	nt 2 EF	R/Outpati	ient 3	DOA	Other <sub>4</sub>	Nur	sing Home 5			ther:
F Vil Physic rrthis	유	1 Yes 2 No 27. Manner of Death				3b. Time	of Injury	28c. li	njury at W	ork?	28d. Descr	ibe how injury of to collision	occurred	
n of \ ling Phy.	ä		Pending A	a. Date of Injur (Month, Day, Youg 10, 2008	ear) 1	051 hrs	5	1	Yes 2	✓ No				
ior tend tor:	a i			e. Place of Inj	ium. At home	o farm	street facto	orv. offic	e building	, etc.	28f. Locati	on (Street and	Number o	r Rural Route Number, City
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6	Could not be I					J, J, J			or Toy	vn, State) Iwood Road (	& Sycam	ore Road, Curtis Bay, M
Divital cours at ours at filled	l H		determined (S	Specify) Ma	jor Road /	Highv	vay							
Hosp 24 ho Func		29a. Certifier 1 Certifyir	ng Physician: To	the best of my	y knowledge,	, death o	ccurred at	the time	e, date and	i piace, a n occurre	and due to the	date and place,	, and due	to the cause(s)
D Fo the Hospital within 24 hours To the Funeral	Medical	one) 2 Medical	Examiner: On the	e basis of examentated.	mination and	or inves	stigation, in	тту орт	11011, 0001			20d Dat	e signed	(Month, Day, Year)
To To	Š	29b. Signature and title of or							ense num	ber		1		
3444		and	2				l	Ο.	C.M.E.			Augus	st 11, 20	JU6
イ		0.000		tod course of a	leath (Item ?	3a)								
		30. Name and address of pe	erson who comple Assistant Me	ted cause of d dical Evan	niner 1	32, 11 Per	nn Stree	t, Balti	imore, l	MD 21	201			
4		,			ar's Signature									
	State		rear)	32 xegistra	a s Signature د ند گرگ	A	Park.	9						
Reg	stra	aug 1	2 2008	I Page 1	J. 18	8	A STATE OF THE STA	111						
DUMBLAT Doug	/2001	Myu I	4	23		ORIG	INAL				00	ME		

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			For Stata Registrar	State of Ma	arylanu	•	ate of Death		eg. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, Last	"Prob	erts	son s	Sy.	2. Date of Deat Month		3. Time of Death
) 	Examin		4a. Facility Name (If not institution, give 5. Social Security Number 6. S	urstvo a	e (in yrs. las	ehob 1	ty, Town, or Location of Dea	A	4c. County of De	ath irthplace (State or Foreign
	Funeral Director			ZM 2□F	83	Yrs. Month			Ž=1924	Ga.
	ehow d.m.	_	10a. State 10b. County			Town or Location				10d. Inside City Limits 1x□Yes 2□No
	28e-f	Director	Md .  10e. Street and Number		вал	timore Ci	_ty Zip Code	1	0g. Citizen of What (	21
	ath with	ralD	4000 E. Northern				21206		USA	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other then "natural, or iteme 23a or 28e-f ehow any injury or other traumetic event, it a Medical Examinar must be notified at another.	by Funeral	11. Marital Status  1 Never Married	12. Was Decedent Armed Forces? ↑☐ Yes 2☐ I If Yes, Give Year or Dates:			cedent of Hispanic Origin? ( pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Black, Wi	nencan Indian, hite, etc. White
21215-0036	within 72 ho jane. r then "natu ir e Medicel	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5		16a. Decedent's Us (Give kind of the life. DO NOT	work done during most of w	orking	16b. Kind of Busines	s/Industry f Maryland
nd	be filed tal Hygie d other event, it	Be	17. Father's Name (First, Middle, Last)			-Auditur	18. Mother's Na	ame (First, Middle, I		I Maryland
Maryland	should be f and Mental P marked of umetic eve	٩	John Ira Rober  19a. Informant's Name/Relationship			19b. Mailing Addre	F1o	ra Hartle Rural Route Number	***************************************	, Zip Code)
	and 2 lealth a m 27 is		Shirley M. Rober	tson Wif		a Diametria (A	4000 E. Nor			
Baltimore,	Pages 1 nent of h int: if ite iry or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation ☐ ☐ Other (Specific	Removal from State	cem	ce of Disposition (A netery, crematory o rison For	r other place)	4-2008	Owings M	
Balti	permit. Page Department important: if any injury or once.		21. Signature of Juperal Service Licer	See	- Gar.	22. Name	and Address of Facility S Belair Rd.	chimunek	Funeral H	ome
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.		1	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. Courdical Due to (or as		2011 C even	<u> </u>			
	Examiner	-e-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	nce of):				
$\sqrt{}$	acuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
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Вох		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal de	eath 3□Ectopic			23d. Date of o	delivery Day Year
ds, P.O.	requires thet the death cer een signed by the attendir hould be detached for use	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulti	ing in the underlying	g cause given in Part I.		bacco use contribute	to the cause of death?  Probably 4 Unknown
Division of Vital Records,	thes by ge 2 st	Completed						24a. Whas a autops perior	med? prior t	autopsy findings available o completion of cause of ? es 2 \( \) No
Vita	eician: Th certificate irector, pag	Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Othor	eath (Check only on		
n of	ng Phy fter this meral d	on: To	27. Manner of Death  1 Matural 5 Pending	2Ba. Date of Inju	iry 2	NOutpatient 3□ 8b. Time of Injury	28c. tnjury at Work?		ence 6 □Other (S ow injury occurred	oecity)
Divisio	To the Hospital or Attending Physician: Ty within 24 hours after deeth.  To the Funeral Director: After this certificate completely filled in by the funeral director, pa	Medical Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not b determined	2Be. Ptace of Inj	jury - At hom ic. (Specify)	M e, farm, street, fact	1 Yes 2 No	28f. Location (S. City or Town		Rural Route Number,
	Hospita 24 hours Funera etely filler	dical C	(Check only 2 Medical Exar	niner: On the basis of	of examinatio	n and/or investigati	ed at the time, date and pla on, in my opinion, death oc	curred at the time, d	late and place, and c	lue to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	D			29c. License number	2	29d. Date signed (Mo	onth, Day, Year)
	00		29b. Signature and title of certifier  Notice of the second of the secon	completed cause of	leath (Itom 3	(Type Print)	1005 746		8/7/0	8
	'JU		N S Ryapa (See	JP 2	25 Mai	1 Sty Suite	200, Reiste	rsto way	MD: 2113	36.
	Sta	ite	31. Date filed (Month, Day, Year)	2008 32. <b>Aé</b> gisti	rar's Signatu	7 Spark				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 2345 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1□M 2MF Months Days Hours 1277871911 579-07-8946 96 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State a or 28a-f show the notified at 1 ☐ Yes 2 No ROCKVILLE MONTGOMERY Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 USA 6121 MONTROSE ROAD by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Black, White, etc. "natural", or Iten dical Examiner 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) ARTIST ART permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Imporant: If Item 27 is marked other the any liury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KELLMAN **POLLOCK** ANNIE LOUIS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3121 OLD POST DRIVE, BALTIMORE, MD 21208 MICHAEL RUBENSTEIN / STEPSON 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition HEBREW YOUNG MEN 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 08/10/2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatire of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to or as a consequence of): /Medical **Examiner** Bucheremi Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2☐ No 3☐ Probably 4☐Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Pengl autopsy performed' A/ shomer 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2002 JEB11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 12 Registrar

ORIGINAL

		•	For State of Ma	aryland / Dep <i>Ce</i>	artment of I <i>rtificate of</i>			iene 0 0	8 25852
	Physici /Medic		1. Decedent's Name (First, Middle, Last) HILDA		RUDOLPH		2. Date of Deat Month	Day the 20	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) SEÁSONS HOSPICE @ NORTHWEST	HOSPITAL	RAN	or Location of Deat	N	4c. County of I	Death I MORE
	Funeral Director		214-14-9980 1□M 2XF 8	e (In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		)20 9.	Birthplace (State or Foreign Country) MD
	e Maryland la-f show	ctor	Usual Residence of Decedent           10a. State         10b. County           MD         BALTIMORE	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the	Funeral Director	10e. Street and Number 2504 SUMMERSON ROAD		10f. Zip Code	209	1	0g. Citizen of Wha	t Country?
9800	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evaninar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Armed Forcas? 1 Yes, Give Year or Dates:	10	Was Decedent of H If Yes, specify Cub 1 □ Yes 2 🛣 No	Specify:		Specify: W	
21215-0036	d within 72 h giene. ir than "nati ire Medice	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5	(Give	edent's Usual Occup kind of work done DO NOT use retire HOMEMAKER	pation during most of wo d)	rking	16b. Kind of Busin	•
Maryland	should be filed and Mental Hy s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) LOUIS BIF	RENBAUM			me (First, Middle, i	,	ILVER
e, Mar	1 and 2 sho Health and tem 27 is mi		19a. Informant's Name/Relationship (Type. Print) DEBRA SAKS / DAUGHTER	32	LAMPLIGH		T, BALTIN	ORE, MD	21208
Baltimore,	t. Partmeir trant		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	RUDOMER \	/EREIN	08/	11/2008	ROSEDALE	, MD
Bal	permit. Pa Departmer Important: any injury		21. Spragure of Funeral Service Vicensee	_ 2	2. Name and Address 8900 REI				OS., INC. LE, MD 21208
	Physician /Medical Examiner		Due to (or as		LVWB C		ac or respiratory ari	est,	Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):					
O. Box	Attending Physician: The law requires that the death certificate be reteath.  reteath.  ector: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the burn	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	☐ Ectopic pregnan ☐ Other (specify) _	су		23d. Date of Month	
rds, P.	luires that the de n signed by the a lid be detached t	by	Part II. Other significant conditions contributing to death b	ut not resulting in the u	underlying cause gi	ven in Part I.	23e. Did to		ute to the cause of death?  Probably 4 Unknown
Division of Vital Records,	1: The law requir ficate has been s r, page 2 should l	Completed					24a. Was a autope perfor 1 □ Yes	an 24b. We sy price dea 2 No 1	re autopsy findings available or to completion of cause of th? ]Yes 2 □ No
of Vit	ding Physician: The lav h. After this certificate has funeral director, page 2 :	n: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpati  27. Manner of Death  28a. Date of Inju	ry 28b. Time o	III 3 LI DOA	her: 4 🗆 Nursing I			SENSOWS (Specify) HOSPICE
ivision	or Attendin fter death. Virector: Aft in by the fun	Certification: To	17型 Natural 5 ☐ Pending (Month, Dail 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide (Month, Dail Investigation 1)	y, Year) Injury ury - At home, farm, st	M 1	rk? ]Yes 2 No	28f. Location (S City or Tow		or Rural Route Number,
	To the Hospital or Atteno within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	f examination and/or i	th occurred at the to	ime, date and plac opinion, death occ	ce, and due to the curred at the time, of	cause(s) and manr	ner as stated. d due to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier	MI P		se number	2	29d. Date signed (	Month, Day, Year) + 10 <sup>+h</sup> 2008
•	4		30. Name and address of person who completed cause of a DS b Grah 12002 2	eath (Item 23a) (Type 5 MAN S	, Print)		STOWN.		

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August **Physician** Year Jackson Stalvey, Jr. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death **Examiner** Square CMOL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/10/1943 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days Months **182X**M 2□ F South Carolina Director 218-42-0996 64 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantines must be notified at 10d. Inside City Limits Baltimore Rosedale Maryland Director 1 ☐ Yes 2XXXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 U.S.A. 8302 Karl Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 200 Married 1 ☐ Yes 2XXXIo If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Construction Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Jackson Stalvey, Sr. Bonnie Lewis Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6462 Highway 905, Conway, South Carolina 29526 Jack Stalvey (Son) imore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Grainger Cemetery 08/11/2008 Longs, South Carolina 4 ☐ Donation 5 ☐ Other (Specify) Balti 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. for Ward F.H. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Imm Mate Cause (Final dise or condition resulting in death) **Physician** Congestive Hea Heart / Medical Examiner \*Poten sion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 4 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
9 Funeral Director: After this certificate has been signed by the attendion physician and Encephalo Path Helatic Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical oaqulo pa yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☐ No in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1☐ Yes 2☑ No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manyler of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the within 2 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

p

DHMH 17 Rev 1/2001

ORIGINAL

Franklin

32 Registrar's Signature

Baltimore, MD, 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kobert

31. Date filed (Month, Day, Year)

9000

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death
 12:40P Month 8-6-2008 Physician John J. Serio, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Home Hospice 4023 Baker Lane Nottingham Balto. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7-29-1930 9. Birthplace (State or Foreign **Funeral** 1 ÅM 2 □ F Months Days Hours Min Md. 78 Director 214-26-0380 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Mexical Expendium these notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 □ Yes 2 ĐNo Md. Balto. Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21236 4023 Baker Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 X No Specify: ģ Specify. 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications Supervisor C&P Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sara Marsiglia John J. Serio.Sr. ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4023 Baker Lane Nottingham, Md. 21236 Mildred Serio 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-11-2008 .Joseph's Fullerton 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a co Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): be detached for use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Inknown To the Hospitai ... within 24 hours after death.

To the Funeral Director: After this certificate has ....

The Funeral Director is a funeral director, page 2 should the funeral director, page 2 should the funeral director. 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 1 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 522 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Invatural 5 Pending investigation 1 DYes 2 No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of row knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner | On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person who cor npleted ca ise of d in 23a) (Type, Print) lowson 7600 Oste my Ayman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

P.O. Box 68760,

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #9 per FH 6882 Maryland Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Rita M. Sova 8-5-2008 5:45P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Balto. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Director 78 212-26-7739 1-21-1930 Baltimore Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "hadical Examination that he multilised at once. Director 1 □Yes 2 X No Md. Balto, <u>Perry Hall</u> 10e. Street and Number 10g. Citizen of What Country? death with 3894 Schroeder Avenue 21128 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f ment of Health and Mental Thomas P. Leonard ဥ Marie Bczyinski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Sova, III 20a. Method of Disposition 3894 Schroeder Ave. Perry Hall, Md. 21128 tion (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-6-2008 Bayview Balto. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. End underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed for use as the burial-trans resulting in death) Last Due to (or as a consequence of): nding physician IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify). P.O. I signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records. 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 4/37/0 5=(2xe2/3 2 □ No 1 ☐ Yes 2 ZNO 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Division of filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Patural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and e of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15500 8.06.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D. 2300 DULANEY RD., TIMONIUM, MD. 21093

Registrar

State

31. Date filed (Month, Day, Year)

AUGUST

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32. Régistrar's Signature

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/Medica Examine	r	4a. Facility Name (If not institution, give	street and number	)	אונטט	4b. City, Town, or	r Location of		August		County of I	Death	5:00	A <sup>M</sup>
		Riverview Nursing 5. Social Security Number 6. Se		ge (In yrs. la	act hirthdowl	Essex If Under 1 Year	If Under	24 Hrs	Date of Die	Baltimore  9. Birthplace (State or Foreign			girts .	
Funeral Director			Пм 2 <b>X</b> Ст /		2 Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da August	7, Year)	916 M	Counti	ace (State o. Iry) Land	r Foreign
and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						10	Od. Inside Cit	ty Limits
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h with the	Funeral Director	10e. Street and Number 4 Cedar Valley Pla	ce Unit	201		10f. Zip Code 21	221			10g. Citi:	zen of Wha	t Count	ry?	
ING 21215-0036  be filed within 72 hours after death with the Maryland tital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funera	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	? No	- 1	Vas Decedent of H f Yes, specify Cuba I □ Yes 2 No	lispanic Ori an, Mexicar Specify:		cify Yes or No Rican, etc.)	-	14. Race - / Black, \	White, e	etc.	
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Marylar d 2 should be th and Ments 7 is marked traumatic ev		19a. Informant's Name/Relationship (7)	rpe. Print)		1	g Address (Street	and Numbe	er or Rural	Route Numb	er, City o	r Town, Sta		-	
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altimore, mit. Pages 1 ar partment of Hea portant: If item : y Injury or othe		1 M Burial 2 □Cremation 3 □F 4 □Donation 5 □ Other (Specify)		CE	emetery, crer.	natory or other place. slaus Ce	m.	Augus 2008	性 13,			-	arylar.	ıd
Baltimor permit. Pages Department of Important: If it any Injury or o once.		21. Signature of Funeral Service Licens	· Conn	ell	11 CC	Name and Address Name IIy F 10 Solle	ss of Facility unera rs Po	l Hom	ne Of D	unda	lk,P.	A.	 1222	
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d unsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events	Due to (or as	s a consequ	ence of):									
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68760, ficate be ex I physician as the burial	edical		d	-								-		
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	/			2	23d. Date o Month		,	Year
res that the de signed by the se be detached in	by Ph	Part II. Other significant conditions co	ntributing to death	but not resu	Iting in the ur	nderlying cause giv	en in Part I		23e. Did t	obacco u	se contribu	ite to the	e cause of d	eath?
Hecords, he law requires t s has been signe ge 2 should be c	ted b								10	Yes 2[	□ No 3[	] Proba	abiy 4 <b>∑</b> j∪	Jnknown
	Completed								24a. Was auto perfo 1∏ Yes		prio dea	r to com th?	osy findings an appletion of ca	available ause of
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On Or or oding Phy h. After this funeral d	tion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	of Injury at Injury 28b. Time of Injury Work?					Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				_		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined						(Street and Number or Rural Route Number, rown, State)						
ne Hospita n 24 hours ne Funera pletely fille	edical	29a. Certifier (Check only one) 1 CertifyIng Phy 2 Medical Exami	sician: To the besiner: On the basis and manner s	of examinat	vledge, death ion and/or in	n occurred at the tirvestigation, in my o	ne, date ar opinion, dea	nd place, a ath occurre	nd due to the ed at the time,	cause(s) date and	and manne I place, and	er as sta I due to	ated. the cause(s	;)
To the To the company	Ξ	29b. Signature and title of certifier	714			29c. Licens	e number	7			e signed (A	Month, E	Day, Year)	
		30. Name and address of person who or	ompleted cause of	death (Item	23a) (Tyno	D6	190	/		8	1111	28		
2		Chukwuma Ebo, 112	4 Mace A	venue,	Balt:		. 212	221						
State Registra		31. Date filed (Month, Day, Year) AUG 1 2 20	662	rar's Signat	de A	المالية								

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**Funer** Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, If I would be a natural to a natified at

Physicia /Medica Examine

1 - State Registrar		C	ertificate of	Death	Reg. I	40. 2008	3 2585	
1. Decedent's Name (First, Middle, L					2. Date of Death Month	Day Year	3. Time of Death	
Joseph M.  4a. Facility Name (If not institution, g			Ab City Town	r Location of Death		8 2008 lc. County of Dea	10:10p <sup>M</sup>	
Stella Maris	,		Towso			more		
Social Security Number 6.	Sex 7. Age (In	yrs. last birthda			8. Date of Birth	9. Bir	thplace (State or Foreign	
219-66-7717	1 <b>X</b> M 2□ F	53 Yrs	i. Months Days	Tiours INIII.	July 5,	1955	MD	
Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or	Location				10d. Inside City Limits	
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10e. Street and Number			10f. Zip Code		10g.	ountry?		
	shire Road	I.		237	USA			
11. Marital Status  1 XNever Married 2 Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 🛣 No	in U.S.	<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	dispanic Origin? (Sp an, Mexican, Puerto	pecity Yes or No- o Rican, etc.)	erican Indian, e, etc.		
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 □ XIII o	Specify:		Specify: W	White	
15. Decedent's (Specify only highest of	Education grade completed)	completed) I (Give kind of work done during most of working I					/Industry	
Elementary/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use retire arpenter	d)		Paul J	. Rach	
10th 17. Father's Name (First, Middle, La	st)			18. Mother's Nam	ne (First, Middle, Maid	en Surname)		
Edward Seald		l Marsh	,					
19a. Informant's Name/Relationship	(Type. Print)	19b. M	ailing Address (Street	and Number or Ru	ral Route Number, Cit	y or Town, State,	Zip Code)	
John Sealover /brother 1311 Shore Road Baltimore MD 21220								
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State								
	1	cemetery, c	crematory or other pla	ce)		_		
1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery, c	crematory or other place Lew Crema	tory 8/	11/08 Ba	altimor	e MD	
1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemetery, c	crematory or other place Crema  22. Name and Addre	atory 8/	11/08 Ba	altimor Ave.Bal	e MD to. MD	
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7

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2300 DULANEY VALLEY RD. DR. ERNESTINE WRIGHT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

Please Type of Print in Black Indelible Int. Topies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ame (First, Middle, Last) 2. Date of Death Day

Laurel

Months Days

10f. Zip Code

1 ☐ Yes 2 🖾 No

16a. Decedent's Usual Occupation

Caregiver

20708

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

Lou Smith

(Give kind of work done during most of working life. DO NOT use retired)

Year

Prince George

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes 2XNo

Approximate Interval Between Onset and Death

4c. County of Death

10g. Citizen of What Country?

Specify:

Homecare

16b. Kind of Business/Industry

Race - American Indian.

Black

Black, White, etc

2008

Aug.

8. Date of Birth (Month, Day,

18. Mother's Name (First, Middle, Maiden Surname)

Sept 29,1936

USA

			For State Registrar		S	State o	f Ma		
			1. Decedent's Nam	e (First, Middle,	Last)				
	Physici /Medio		Norma	Jean		Si	mmon		
	Examir		4a. Facility Name (i	f not institution,	give stre	et and nu	mber)		
			13601 Ba	rnet La:	ne,	Apt.	#14		
	Funeral		5. Social Security N	umber 6	6. Sex		7. Age		
	Director		097-34-7	006	1 🗆 N	1.2 □ <b>X</b> F			
	TO		Usual Residence of	Decedent					
	ylan		10a. State	10b. County					
	a-fsh	ctor	MD	Prince	Geo	rge			
	7 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ire	10e. Street and Nu	mber					
	23a c	Funeral Director	13601 Ba	rnet La	ne,	Apt.	#14		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. mportant: if item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, if a Medical Exartinal mental be notified at 2006.	ne	11. Marital Status	12.	Was Dec	edent E			
ဖွ		豆	1 ŽNever Married 2 ☐ Married 1 ☐ Yes						
03	ral",	b	3 Widowed	4 Divorced		Year or D	ve lates:		
5-0	72 hc "natu	etec	15. Decedent's Education (Specify only highest grade completed)						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Practical Example.	Completed by	Elementary/Seco	ndary (0-12)		College (	1-4or 5+		
Þ	othe ent,	Be C	17. Father's Name	(First, Middle, La	ast)				
<u>lar</u>	ald be Aenta rked tic ev	일	Leroy S	immons					
ar <sub>y</sub>	shou and h ma uma	-	19a. Informant's N	ame/Relationshi	р (Туре.	Print)			
Σ	alth a		Gary Sim	mons/ S	on				
ē	s 1 a of He of he other		20a. Method of Dis						
<u>ii</u>	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, It Italy DICE.		1 🖾 Burial 2 l 4 🗆 Donation	☐ Cremation 3 5 ☐ Other (Spe		noval from	State		
at	permit. Departn Importa any Inju		21. Signature of Fu	neral Service Li	censee		112-		
8	8 9 E 8 8		2. Ke	n Stile	>		M01		
			23a. Part 1. Enter t shock, or hea	he disease, or c rt failure. List o	omplicat	ions that cause on e	caused t		
	Physician		Immediate Cause disease or condition				Ma		
	/Medical		resulting in death)	4	7 a	Due to	(or as a		
	Examiner								
			I Commonstatt Statement	and the same	h h				

Examine

Physician/Medical

þ

Completed

Be

Certification: To

Medical

29a. Certifier

31. Date filed (Month, Day,

Simmons

12. Was Decedent Ever in U.S.

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (item 23a)

Year)

AUG

7. Age (In vrs. last birthday

71

Laurel

10c. City, Town or Location

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mmons/ Son 13601 Barnet Lane, Apt. #14, Laurel, MD 20708 20b. Place of Disposition (Name of **Highterest**al **Alberty** p**we**st 20c. Location - City or Town, State Date 2 Cremation 3 Removal from State 2008 Savannah, GA n \_5 ☐ Other (Specify) Funeral Service Licenses 22. Name and Address of FacilityDonaldson Funeral Home, P.A. M01053 313 Talbott Ave., Laurel, MD er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, neart failure. List only one cause on each line. se (Final lition th) Metas Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 522 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

law requires that the death certificate be executed burial-transit attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, cate has been signed by the page 2 should be detached certificate ospital or Attending Physician: Thours after death.
Ineral Director: After this certificat filled in by the funeral director, pa

To the Hospital or within 24 hours af To the Funeral D

State Registrar (Type, Pr

1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

			For State Registrar	State of Maryland	d / Department of H Certificate of I		ntal Hygien	Z 11 11 18 -	25859
3	Physicia /Medic		Decedent's Name (First, Middle, Last)	Constan	ee Sada		Date of Death Month Date MGMS+	5 , 2000	3. Time of Death 2: K P M
) Vi	Examin	4.0	4a. Facility Name (II not institution, give stre St- C-11 Zabeth (	WSING (	enter 1	Location of Death		County of Death	
	Funeral Director		5. Social Security Number  219-10-4285  Usual Residence of Decedent	7. Aga (In yrs. I	Months Dave	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day, Year, Jan. 24,	1922 Mar	place (State or Foreign ntar) y Land
	Maryland f show	tor	10a. State 10b. County Maryland N/A		n, Town or Location				10d. Inside City Limits 1   Yes 2  No
	sa or 28e-	Direct	10e. Street and Number 3300 Benson Ave		10f. Zip Code	21229	10g. Ci	itizen of What Cou USA	intry?
036	be filed within 72 hours after death with the Maryland that Hygiene. ed other then "natural; or itema 23a or 28e-1 show event; the Medical Examinat must be notified at event.	by Funeral		Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Decedent of H If Yes, specify Cuba 1 Tyes 2 XNo	ispanic Origin? (Specin, Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
Maryland 21215-0036	d within 72 ho giene. Ir than "natur	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Bookeeper	during most of working	7 16b. F	Kind of Business/li	•
and	ntal Hygined other	Be	17. Father's Name (First, Middle, Last)	C-	11	18. Mother's Name (			
ary is	s 1 and 2 should be I Health and Mental Item 27 is marked other traumatic ev	ှင	Vincent  19a. Informant's Name/Relationship (Type)		dauskas 19b. Mailing Address (Street)		Anna Route Number, City	Kuler or Town, State, Zi	
	of Health ar item 27 is rother trau		Geraldine Mouser	(Niece)	1280 Abrams R				
Baltimore,	permit. Pages 1 Deportment of He Important: If the any injury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State Lo	lace of Disposition (Name of emetery, crematory or other place udon Park Cemet		08 Bal	ocation - City or I	Maryland
Ball	Departiment Important in once		21. Signature of Funeral Service Licensee			ens Ave., I			
	Physician /Medical		23a. Part Lever the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death cause on each line.  Due to (or as a copsequence)	Do not enter the mode of dyin	diseas	respiratory arrest,		Approximate Interval Between Onset and Death
*	Examiner	JE.	Sequentially list conditions, b	Due to (or as a consequ		rtery	dista	1-e	Years
$\int$	be executed ician and burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			/			•
8760,		dical Ex	d.	Due to (or as a consequ	dence or):				
P.O. Box 68	the death certific y the attending p ched for use as	Physician/Medi	IF FEMALE: 23c  33c  in the past 12 months?  1 □ Yes 2 No  9 □ Unknown	. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3 Ectopic pregnancy	,		23d. Date of delin	very Day Year
	8 6 8	by	Part II. Other significant conditions contri	buting to death but not rest ${\cal N}$	ulting in the underlying cause giv	en in Part I.		N.A.	the cause of death?
of Vital Records,	The ate ha	Completed	Dementia				24a. Was an autopsy performed? 1 ☐ Yes 2 N	death?	opsy findings available ompletion of cause of
Z:E		To Be	25. Was case referred to medical examiner?  1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □ DOA Oth	er: ANursing Hom	Check only one)  B 5 Residence	6 ∏Other (Spec	(h)
n of	ing Phys Viter this uneral di			28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. Injury Wor	y at 28	Bd. Describe how inju		
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation	28e. Place of Injury - At ho building, etc. (Specify	M 1 □	Yes 2 □No	18f. Location (Street and Number or Rural Route Number, City or Town, State)		
_	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical Ce			wladge, death occurse at the tir tion and/or investigation, in my o				
	To the within To the comple	Me	29b. Signature and title of certifier	nn	29c. Licens	e number	Α	ate signed (Month	
7	H		30. Name and address of person who com	70 11	Λ.	Baltim	Au M	1	6,2008 nd 21227
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1. 2 200	32. Segistrar's Signa	, , , , , , , , , , , , , , , , , , , ,	DUITION	0, 0	aryla	na cice

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ANICE CHORES 6:00PM AUGUST 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F 266-04-9627 Aug. 6, 1946 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notifiled at 1 ☐ Yes 2 No MD Director Baltimore d 2 should be filed within 72 hours after death with the I th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-traumatic event, the Medical Examiner must be notifi 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 5224 Wasena Avenue 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Carl Wilbur Dixon Margaret Elizabeth Groszer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Mr. Frank Shores/Husband 5224 Wasena Avenue Baltiomre, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug. 11, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 2008 Elkridge, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee 1 2nd Avenue SW Glen Burnie, MD 21061 Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEMORRHAGE INTRACRAMIAL 2 KAQ 41 **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, loading to himselect cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the a 9 I Inknown 9 Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, CIVIHOSIS HEPATIC 1 Yes 2 No 3 Probably 4 donknown Completed DIABETES MELLITUS TYPE II 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 autopsy certificate 2 No 1□ Yes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To th. within 24. and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier the Equara M-D RES 000 AUGUST 7 2008 MARYLAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IHEAGWARA, 3001 SOUTH HAWOVER STREET, BALTIMORE, 3 II KO 21225 3 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

AUG 12

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 29d per dr. 4882:08/12/08dbb

			1103101111	Item 29d per	dr. egg	87 ic 28 17	1983hb			800	25861
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Rose	Suda				2. Date of Dea Month July	ath 30,1 200	8 <sup>Year</sup>	3. Time of Death 4:15P M
N. A.	Examin		4a. Facility Name (If not institution, give s Suburban Hospital	treet and number)		4b. City, Town, o	or Location of Death			ty of Death	mery
	Funeral Director		102-10-4170	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da) 01/02/	h y, Year) 11924	9. Birthpl Count	ace (State or Foreign try) NY
	aryland show	٥٢	Usual Residence of Decedent  10a. State 10b. County  NY Suffolk		ty, Town or Lo	cation				10	od. Inside City Limits  1X Yes 2 No
	with the M a or 28a-f	Funeral Director	10e. Street and Number  12 Jefferson Street			10f. Zip Code 11730			10g. Citizen of USA	What Count	
920	within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-f show the Medical Exandrer mast be rediffed at	þ		2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:			Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Display Rican, etc.)	14. Ra Bla	ace - America ack, White, e ify: Whit	etc.
215-0	within 72 hou lene. than "natura he Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of world	king	16b. Kind of E		lustry
Baltimore, Maryland 21215-0036	be filed ital Hygi d other event, I	To Be Col	12 17. Father's Name (First, Middle, Last) Frederick Bayer			Beautic	18. Mother's Nam Jenn			Salon mme)	
Mary	she in it	F	19a. Informant's Name/Relationship (Typ. Joanne Ali/ Daugh		tand Number or Ru irport Bo						
more,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition  1X Burial 2 □ Cremation 3X□ Re  4 □ Donation 5 □ Other (Specify)	emoval from State Oa		Date 04/2008	20c. Location Bay	Shore			
Balti	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  Dorota Marshall  Charles L. Steve 1501 East Fort 7								ral Hom	e Inc	D 21230
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deat e cause on each line.						111	Approximate Interval Between Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a consequent							
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence Malnut							
68760,	rtificate be executed ng physiclan end as the burial-transit	fedical Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
O. Box	death ce e attendii id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	ıldeath 3□	Ectopic pregnan	ісу			ate of delive	ory Day Year
ds, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause gi	ven in Part I.				e cause of death?
of Vital Records,	The ate h	Completed								o. Were autop prior to con death? 1 □ Yes	osy findings available inpletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Lot	26. Place of Dea				
of	Phys this	5	1 ☐ Yes 2 ☒ No	her: 4  Nursing H	ome 5 Resid			()			
sion	Attending r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	Injury	Wo	rk? ]Yes 2 □No	Edd. Bederide i			
Division	path	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	fy) 			City or Tou	vn, State)		l Route Number,
	the Hospital hin 24 hours a the Funeral I upletely filled	Medical	(Check only 2 Medical ExamIr one)	Iclan: To the best of my knower: On the basis of examination and manner stated.	ation and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and place	e, and due to	
D	To the l	Me	29b. Signature and most of certifier  30. Name and address of person who con	- NO	Hospi	129c. Licen	se number	66200	29d. Date sign	10708	Day, Year)
	20)		30. Name and address of person who con	mpleted cause of death (Iter	n 03a) Jype,	Print Bet1	resola,	no a	20814	7	
	Sta	Od Data Blad (March Day Vond) 80 Decistrate 8									

25862

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 July 28, **Physician** 9:00 AM M George R. Summerville /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Lanham 9125 Alcona Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**X**) M 2□ F Yrs. Hawaii 217-46-9339 Jan 3, Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County item 27 ie marked other than "naturel", or iteme 23a or 28a-1 ehow other traumatic event, the Medical Exactings must be notified at 1 ☐ Yes 2√ No Director Prince George's Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9125 Alcona Street 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) civil engineer Dept of Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 ie marked other ye injury or other traumatic event Be James Summerville Bessie Laskawitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Chad Jorgensen/nephew 18850 Nalle Road N. Fort Myers, FL 33917 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 NOther (Specify) in state 22. Name and Address of Facility Kon all Service Licensee Director State Anatomy Board 655 W. Baltimore Street 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DIABETES MELLITUS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examiner nding physicien and use as the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month Day Year 5 Other (specify) P.O. I sate has been signed by the case page 2 should be detached: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown HYPERTENSION Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate 21 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/2 No 1 🗌 Yes Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after death. Natural 5 Pending 1 Tes 2 No М investigation 2 Accident filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier MO 56058290 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STIL SARVIS AVENUE SUITE AW RIVERDALE NO 20737 SURUSHKUMAR HIATTUN 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OSAGA) AUG 12 2008 Registrar

08-06003 Candida Tuazon

Please Type or Print in Black Indelible Ink. Ensemble State of Maryland / Department of Health and Certificate of Death	ure All Copies Are Legible. and Mental Hygiene	200	08 2586
ent's Name (First, Middle,Last)  NDIDA PENA TUAZON	2. Date of Death Month Day August 6, 2008	Year	3. Time of Death 1027 hrs

		- For State Certificate o	f Death	Reg.		
Physicia		1. Decedent's Name (First, Middle,Last)		Date of Death     Month     Date	V 1	Time of Death
☐ I Examir		CANDIDA PENA TUAZON		August 6, 20	008	1027 hrs
	•	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Johns Hopkins Hospital	Baltimore			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs  Months Days Hours Min.		MM/DD/YYYY) 9. Birthpla Foreign	ace (State or
Director	- 1	219-94-2512 1 M 2XXF 88 Yr		Oct. 3,	Countr	Philippines
	H	Usual Residence of Decedent				
any	Ī	10a. State 10b. County 10c. City, Town or Loca	tion			d. Inside City Limits
show ce.	_	MD Prince George's Laruel			1	Yes 2 No
Aaryland 28a-f show 1 at once,	왕	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country	?
th the Maryland 23a or 28a-f sho notified at once.	Director	8310 Holly Street	20707	}	U.S.A.	
vith t	— L		as Decedent of Hispanic Origin? ( Sp		14. Race - American	Indian, Black,
eath wi	Fune	1 Never Married 2 Married	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
f., or		3 XX Widowed 4 Divorced If Yes, Give Year 1	Yes 2 XXNo specify:		Specify: Asia	n
hours afte 'natural'', Examiner	<del>g</del>	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of vectors) of working life. DO NOT use reti		6b. Kind of Business/Indu	ustry
72 ho	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	TIOST OF WORKING LITE. DO NOT USE TELL	rea)		
336 thin 72 than edic 4		Grade 5 Home	maker		Own Home	
5-0036 led within 72 ttygiene. other than '	3	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medic.	Be	Camilo Pena	Catalina	a Tulio_		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	P		ng Address (Street and Number or			
MD and 2 shoulth and m 27 is aumatic			Kilcroney Court	Laurel	Maryland 20c. Location - City or To	20707
Baltimore, ME permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other trauma	Ш	crematory of (	osition (Name of cemetery, other place)	Date	20c. Location - City or 10	wn, State
Baltimore, permit. Pages I an Department of Hes Important: If iter injury or other tr	м	Burial 2 Cremation 3 AARemoval noth state		/27/2008	Mabalacat,	Philippines
Itir Fartme	ı	4 Bollatoli & Greeky.	Name and Address of Facility al			200
Balt permit. Depart Impor		$\sqrt{M_{00770}}$ 13	13 Talbott Avenue	e Laurel	. Maryland	20707
hysician		23a. Fart N nter the disease or complications that caused the death. Do not enter failure. List only one cause on each line. Intrabronchial	the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Viedical		Immediate Cause (Final disease a. granulomatous lung	disease & hypert	ension d	uring	Death
∠xaminer		or condition resulting in death)  Due to (or as a consequence of): brone	choscopy			
		Sequentially list conditions, b.				
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
	am	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, crate be executed physician and the burial - transit		d				
exectian antial - th	/Medical	X UNPENDED AMENDED 23a,27,28a-f	, perME, g884 10/	7/08 TT		
68760, certificate be nding physic se as the bur	Nec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
387 rtific ling p			Fetal death 3 Ectopic pregr	nancy	Month Da	y Year
Box 6 death ce the attend	sici	4 Pregnant at time of death 5	Other (Specify)			
P.O. Box 687 s that the death certific gned by the attending is edetached for use as t	Physician	Part II. Other significant conditions contributing to death but not resulting in the	o underlying cause given in Part I	23e. Did tob	pacco use contribute to th	e cause of death?
P.O. es that the igned by be detach	by F	Part II. Other significant conditions Continuing to death but not resulting in the	e dilucitying cause given in tare is		2 No 3 Proba	
S, F uires i n sign	ed			24a. Was a		psy findings available
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Vita ysicia nis ce direc	ω .	examiner?  1 Vers 2 No Hospital: 1 Inpatient 2 ER/Outpatient	ent 3 DOA Other Nurs	sing Home 5	Residence 6 Other:	
Division of Vital Records, tal or Attending Physician: The law require is after death. There this certificate has been sited in by the funeral director, page 2 should b	. To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time			ow injury occurred	-
ion tendin eath. tor: A	tior	1 Natural 5 Pending 0/6/09	1 Yes 2 XNo		ial biopsy p	
riSi r Att er de irecte n by t	lig	2 21 Accident 28e. Place of Injury - At home, farm, s	treet, factory, office building, etc.	28f. Location (S	street and Number or Rura tate) Johns Hop	Route Number, City
Divisi pital or At ours after d	Certification:	4 Homicide determined (Specify) hospital		Baltimo	ore, MD	KINS HOSPT
84 4 E e		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death on	curred at the time, date and place, ar	nd due to the cause	e(s) and manner as stated	d.
To the How within 24 h To the Funcompletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigant manner stated.	gation, in my opinion, death occurred	at the time, date a	and place, and due to the	cause(s)
F 2 2 8	₹	29b. Signature and title of certifier	29c. License number		29d. Date signed (Moni	th, Day, Year)
V.		Do milling	O.C.M.E.		August 7, 2008	
1 6. 7		30. Name and address of person who completed cause of death (Item 23a)				
, Ormi	Ī	Donna M. Vincenti, MD Assistant Medical Examiner 1	11 Penn Street, Baltimore,	MD 21201		
S	tate	31. Date filed (Month, Day, Year) Registrar's Signature	-4			
Regis		AUG 1 2 2008 Mague. It for	de .			

ORIGINAL

DHMH 17 Rev 1/2001 CCME 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 1000 A M AUGU67 2008 HARVEY VENABLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDALLSTOWN BALT IMORE NORTHWEST HUSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 4-15-1923 Sex 1 M 2 F Birthplace (State or Foreign Country)
 Table 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 229-18-5162 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me Ical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Windsor Mill Directo MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 USA 3819 Coronado Road Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify African-American 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4or 5+) Bethlehem steel Crain Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jerry Venable Mariah Jeter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vanessa Bass/ Daughter 3824 Coronado Road, Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 8-16-08 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tylie Funeral Home P.A. of Balto. Co. 21. Signal 9200 Liberty Road, Randallstown, MD 21133 36. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastati disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transi attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 X No 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Tripatient Certification: To 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D6059736 Obstrank mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 NORTHWEST HOSPITAL OLD WERT ROMO EITER ATMICE MP. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State De wee 2008 Registrar

Amend # 2, per MD G882 8/20/08 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #17 per Fh g882 8/12/08 TT
State of Maryland / Department of Health and Mental Hygiene
State Amend item#20b, perFH, G882, 8/15 Costill Sate of Death

1- State Amend item#20b, perFH, G882, 8/15 Costill Sate of Death

Reg. No. 2008 2. Date of Death Aug.
Month Day 9,2008. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5.55PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner Rosedale Square Baltimore 1-tospital s. last birthday, 3 Yrs. 8. Date of Birth Month, Day, If Linder 1 Year thplace (State or Foreign **Funeral** Hours Min. 1 M 2 F Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** town 10f. Zip Code Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 Yes 29 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Completed by 3 Widowed 4 □ Divorced lac or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ire. DO NOT use retired) Elementary Secondary (0-12) College (1-4or 5+) ARE TROVICE Robert Amos To Be Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2123 Important: If Item 27 is any injury or other trai once. NAlker Kida eborne Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donalion of Funeral Service Litensee Signatu Fulton rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or reset failure. List only one cause on each line. Approximate Interval Between Onset and Death In ediate Cause (Final sease or condition resulting in death) **Physician** days ntracerebral Hemorrhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 FRANKLIN Square Balto md DR Sandra Groot DR 31. Date filed (Month, Day, AUG 1 Year) 2. Registrar's Signature State 2008 2246

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 5:55 PM Aug 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 54 Carling Circle Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Apr. 9ay, 7. Age (In yrs. last birthday) (State or Foreign Social Security Numb **Funeral** 1947 Mary land 218-48-1906 **™** M 2 □ F 61 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Exambra trust be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21227 54 Carling Circle Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

int: If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces?

\*\*TOTAL PORT OF THE PROPERTY OF T Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. White þ Specify: 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna E. Keene Hubert C. Woolridge ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 54 Carling Circle, Baltimore, MD 21227 Dorothy Stanson - Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Department of H Important: If ite any Injury or ot XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 8-8-2008 Brooklyn, MD 5 Other (Specify) Donation 2. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-tran P.O. Box 68760€ Due to (or as a consequence of) Physician/Medical signed by the attending place as IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To the Hospital Committee within 24 hours after death.

To the Funeral Director: After this of the Funeral directors and the funeral directors and the funeral directors. 1 Yes 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c/Nicense number

29d. Pate signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Blanche Marie Weinkam 2008 August 12:30PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3438 Arcadia Drive Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day April 16, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) Year) 1919 1 □ M 2 💢 F 89 212-05-2317 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1221 Ten Oaks Road 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify White Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John R. Schaefer Margaret E. Walsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Carmel Rainville, Daughter 1846 Sutton Avenue Relay, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 08/12/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor Thomas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CHFdisease or condition resulting in death) Due to (or as a consequence of): CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Culsease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1∐ Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No

Examiner Division of Vital Records, P.O. Box 68760. re Hospital or Attending Pl 24 hours after death. e Funeral Director: After t

**Physician** 

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**Funeral** 

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medical

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Certification: To

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altimore, Maryland 21215-0036

C O P D, Atrial Fibrillation, Hypertension Completed 25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

DOUT & UY (0

29d. Date signed (Month, Day, Year)

8/11/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Victor Madrid MD 31. Date filed (Month, Day, Year)

Catonsville, Maryland 21228 700 Geipe Road 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 25868 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1622 PM Margaret Virginia White 08 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M & St-F Months Days Hours Min. 212-28-7100 80 Yrs Director 06/10/1928 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Maryland Baltimore Essex 1 ☐ Yes 🎗 🔯 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1002 Cedar Creek Road Funeral 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 ☑ XIo Specify Specify. ģ XX Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event, the onee. Homemaker Pages 1 and 2 should be filed vent of Health and Mental Hygient: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Simpson Helen Averv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa White (Daughter) 1926 South Ridge Road, Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 08/13/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part I ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ipm ediate Cause (Final isease or condition resulting in death) **Physician** Laclure 40 /Medical de to (or as a consequence of): **Examiner** Severe de Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tra Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Day Month Year 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 2 ER/Outpatient 3 DOA ٩ 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Natural 2 Accident 1 ☐ Yes 2 ☐ No Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funeral E

Division or Vital Records, P.O. Box 68760, MARGAR Hospital or Attending Physician: WITTE

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Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Lisa Kirkland

29d. Date signed (Month, Day, Year) 108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WOODSON augus 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 130N SECOURS HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Y)
June 12, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year Months Days Hours Min 1 □ M 2 💢 F 198-01-9808 93 **Director** 1915 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Medical Examiliar must be netitied at h Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 N. Smallwood Street #224 21223 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 X No Specify. Specify: black 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) private homes domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miles Ned Holman Mary Bridgeford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Howard/niece 7004 Park Heights Avenue #K3 Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signa pre d Funeral S Ronald State Anatomy Board 655 W. Baltimore Street Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate C e (Final disease or con flion resulting in death) HYPERTENSIVE Physician CARDIOVASCULAR /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed HROHIC and burial-trar P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown n signed by ti Id be detach⊌ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 director, page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has 24a. Was an certificate 1 □ Yes 2 1No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea... al Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6,2008

State Registrar 31. Date filed (Month, Day, Year) AUG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



SECOURS

08-06053		Please Type or Print in Black Indelible Ink. Ens	ure All Copies Are Leç	jible.
Shawn Lamont V		Iver, Sr. State of Maryland / Department of Health 1- For State Certificate of Death Registrar	-	g. No. 2008 2587
Physicia Medical Examir	n/	1. Dependent's Name (First, Middle, Last)  1. Dependent's Name (First, Middle, Last)	2. Date of Death Month August 8, 2	Day Year
		4a. Facility Name (if not institution, give street and number)  University Hospital  4b. City, Tow Baltimore	n, or Location of Death	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months Yrs.	Year If Under 24Hrs. 8. Date of Birt Days Hours Min.	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
è	Ì	Usual Residence of Decedent  10a, State   10b. County   10c. City, Town or Legation		10d. Inside City Limits
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ith the Maryland 23a or 28a-f show notified at once.	Director	106. Street and Number 106. Zip Co	1225	lg, Citizen of What Country?
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Armed Forces? If Yes, specify C	of Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.)	White, etc.
2 hours afti "natural" Examine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occ	No specify: Supation (Give kind of work done glife, DO NOT use retired)	Specify: 2/17C/\ 16b. Kind of Business/Industry
1215-0036 Id be filed within 72 hours after death wi fental Hygiene. anked other than "natural", or items event, the Medical Examiner must be	Completed	Elementary/Secondary (0-12) $\int_{-\infty}^{\infty} \frac{\text{College (1-4 or 5+)}}{\sqrt{2}} \int_{-\infty}^{\infty} \frac{1}{\sqrt{2}} \frac{1}{\sqrt{2}} \int_{-\infty}^{\infty} \frac{1}{\sqrt{2}} \frac{1}$	MP10 YEC	CARPENTER
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	17. Falher's Name (First, Middle) Last)	18. Mother's Name (First, Middle, N	WEAVEC
and 2 should tealth and M tem 27 is m traumatic e	2	19e. Informant's Name/Relationship (Type, Print)  19b. Mailing Address  19b. Mailing Address	Street and Number of Rural Route Muni	ber, Sity or Town, State, Zin Code)
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of Disposit	of cernetery, Date	20g Location - City or Town, State
Baltimo permit. Pag Department Important: injury or of	~	4 Donation 5 Other Specify:  27 Signature of Funeral Service Licersee  22. Name and Add  27 Fine Add  28 Fine Add  29 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  21 Fine Add  22 Fine Add  23 Fine Add  24 Fine Add  25 Fine Add  26 Fine Add  27 Fine Add  27 Fine Add  28 Fine Add  29 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  21 Fine Add  22 Fine Add  23 Fine Add  24 Fine Add  25 Fine Add  26 Fine Add  27 Fine Add  27 Fine Add  28 Fine Add  29 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  20 Fine Add  21 Fine Add  22 Fine Add  23 Fine Add  24 Fine Add  25 Fine Add  26 Fine Add  27 Fine Add  27 Fine Add  28 Fine Add  27 Fine Add  27 Fine Add  28 Fine Add  27 Fine Add  28 Fine Add  27 Fine Add  28 Fine Add  28 Fine Add  27 Fine Add  28 Fine Add  27 Fine Add  28 Fine	dress of Facility	P. G. AlMORE MCKEAU
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of defailure. List only one cause on each line.	ving, such as cardiac or respiratory arre	st, shock, or heart . Approximate interval Between Onset and
xaminer	İ	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):		Death
	iner	Sequentially list conditions, if any, leading to immediate  The Control of Course  Due to (or as a consequence of):		72
uted nd ransit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
1760, ficate be execute g physician and the burial - tran	edical	UNPENDED AMENDED		
68 certi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify)	3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
P.O. I s that the gned by t	Ď.	Part II. Other significant conditions contributing to death but not resulting in the underlying car		bacco use contribute to the cause of death?  2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box ral or Attending Physician: The law requires that the death is after death all Director: After this certificate has been signed by the attered in by the funeral director, page 2 should be detached for use	Completed		1 24a. Was a autops perfon	24b. Were autopsy findings available prior to completion of cause of death?
tal R	ğ.		Place of Death (Check only one)	
of Vi	<u>ان</u>	(Month Day Year)	Injury at Work? 28d. Describe h	Residence 6 Other:
Ivision Or Attendi after death Director: A	catio	2 Accident Investigation 28e Place of Injury At home form street factors of	Yes 2 No Subject shot	
DIVI Hospital or 24 hours afte Funeral Directely filled in	Certification:	4 ✓ Homicide determined (Specify) Local Street	or Town, St	treet and Number or Rural Route Number, City ate) ks Road, Baltimore , MD
To the Ho within 24 I To the Fu	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time one)  2 Medical Examiner: On the basis of examination and/or investigation, in my ople and manner stated.		
	Ž		cense number .C.M.E.	29d. Date signed (Month, Day, Year) August 8, 2008

DHMH 17 Rev 1/2001 OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Ling Li, MD

111 Penn Street, Baltimore, MD 21201

ORIGINAL

OCME

08-06120 Erio

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Eric Wess	1-	State For State	of Maryland / Di	Certificat	e of E	Death		, 3	Re	g. No.	20	00 050
Physiciar	Re	gistrar Decedent's Name (First, Middle,Last						2.	Date of Deat	h Day	Year	3. Jim@of Deam 7 0 2058 hrs
Medical Examin	-	Eric John					1100.5		Month August 10	, 2008	unty of Death	20301113
HER !	4	a. Facility Name (if not institution, give	e street and number)			City, Town, or Lo Rosedale	cation of L	Death		Baltimpre County		
		Franklin Square Hospital		yrs. last birthd		If Under 1 Year	if Under 2	24Hrs.	8. Date of Bir	th(MM/DD/	YYYY) 9. Birti	hplace (State or
Funeral Director	- 1	Social Security Number 6. Sec 213-08-9272 1X	M 2 F		Yrs.	Months Days	Hours	Min.	May 9,			n untry) MD
	ι	sual Residence of Decedent	140-	. City, Town or	Location	)						10d. Inside City Limits
d how any		0a. State 10b. County Baltim		Baltim	ore						CONTRACTOR	1 Yes 2 X No
Marylan	Director	Oe. Street and Number  25 Dallington	Court			10f. Zip Code 21128				USA	of What Cour	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ᇹ	Marital Status     Never Married 2 Married	12. Was Decedent Eve		13. Was	Decedent of Hispa s, specify Cuban,	anic Origir Mexican, F	n? (Spec Puerto R	cify Yes or No ican, etc.)		White, etc.	ican Indian, Black,
fter dea		3 Widowed 4 Divorce	if Yes, Give Year		1`	Yes 2 X No	specify:		d dono		ecify: W N :	ite
ours al	by by	15. Decedent's Education (Specify of	nly highest grade comple	ted) 16a. D	ecedent's uring mos	s Usual Occupationst of working life. I	on (Give kii DO NOT u	ina of wa ise retire	d)			e Spice
36 n 72 h nan "n lical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	F	orm	ulator					pany	
21215-0036 Jud be filed within 7 Mental Hygiene. marked other than ic event, the Medica	[	17. Father's Name (First, Middle, Las	t)			1			First, Middle		rname)	
215 e filec tal Hy ked o	8	Robert Wess,	Sr.			Address (Street	Debo	oral	n Hynes	imbor City	or Town State	e Zin Code)
213 ould b d Men s mar lic eve	리	19a. Informant's Name/Relationship (		1 2	Mailing	Double	and Numb	perorki ck 1	Jane Ba	1timor	e. MD	21234
MD od 2 sho alth and m 27 is aumati		Robert Wess,  20a. Method of Disposition	Sr./ Fath			tion (Name of cen			Date	20c. Lo	cation - City o	r Town, State
Ore, es l ar of Hee If ite		1 Burial 2 X Cremation 3		Evans	in of off	heral		08/	13/08	For	est H	ill, MD
Baltimore, permit. Pages I ar Department of Hei Important: If ite	-	4 Donation 5 Other Specific 2/L Signature of Funeral Service Lice	у: ensele	Chape	22. N	Bel Air	of Facility	1 C1	hamal &	Creme	tion	Services
Ba perm Depa Impo		1 0 0001111.07	PINIA		88	00 Har	ford	Rď	Parky	ille,	MD 21	234 Approximate Interval
Physician	1	23a. Part I. Unter the disease, or cor failure. List only one cause on	oplications that caused the	e death. Do no	t enter th	ne mode of dying,	such as ca	ardiac or	respiratory		K, Of House	Between Onset and Death
Medical aminer		Immediate Cause (Final disease or condition resulting in death)	a. ALcohol at Due to (or as a conseq	nd narc	otic	(morph)	ine)	into	xicat.	LOII		
`		Sequentially list conditions,	b				_					
	iner	if any, leading to immediate	Due to (or as a conseq	uence of):								
_ ;i	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):								4
xecuted n and - transit		X UNPENDED	d. AMENDED 23a	,27,288	ı-f,	perME,	g882	8/18	3/08 T	T		
60, ate be exe hysician e burial -	Physician/Medical	IE EEMALE:	23c. If yes, outcome							23d.	Date of deliver	ery Day Year
Box 6876  He death certificate  y the attending phy hed for use as the	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at ti	C 1 1 h		etal death 3 ther (Specify)	Ectopi	ic pregna	ancy		WOTH	bay
OX (leath cr	ysic	1 Yes 2 No 9 Unkno	own g Unknown									to the cause of death?
P.O. Box 68760, es that the death certificate be igned by the attending physic pe detached for use as the but	Ph.	Part II. Other significant condition	s contributing to death	but not resultir	ng in the	underlying cause	given in P	art I.				Probably 4 Unknown
s, P. iires th isigne d be de	od by								24a. W	/as an	24b. Were	autopsy findings availab
ords w requas beer	Completed								p	utopsy erformed?	death	
<b>Rec</b> (The la Cate his page 2	Ę					OC Place	e of Death	h /Check		es 2 N	1 🗸	165 2 110
ian: certifi	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2 🗸 ER/0	Dutnatier		Other <sub>4</sub>		ng Home 5	Reside	nce 6 O	ther:
F Vid Physic or this	₽	1 V Yes 2 No 27. Manner of Death	28a. Date of Inju	y 28b	. Time of		ury at Wo	rk?	1		ry occurred	
nof nding l h. Afte e funci	<u> </u>	1 Natural 5 Pendir	(Month, Day,Y	ear)	k	1	Yes 2	X No	unk			
Division of Vital Records, P.O. B pital or Attending Physician: The law requires that the dours after death. After this certificate has been signed by the filled in but the fineral director, page 2 should be detached	Certification:	2 Accident Investi 3 Suicide 6X Could determ	not be 28e. Place of In	ound at	farm, str	eet, factory, office idence	building,	etc.	28f. Locati or Tov Perry	on (Street a vn, State) 2 7 Ha11	nd Number of 5 Dow1	r Rural Route Number, Ci ngton Ct
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and momental view in the fineral pirector, page 2 should be detached for use as the burial - transit			rsician: To the best of miner:On the basis of examiner	y knowledge, d	eath occ	curred at the time,	date and p	place, ar	d due to the	cause(s) ar	nd manner as	stated. to the cause(s)
To the within To the	Medical	one) 2 Medical Exam	iner:On the basis of exa- and manner stated.	milation and/o			nse numbe			290.	Date signed	(Month, Day, Year)
	2	29b. Signature and title of certifier	el us			l l	C.M.E.			Aug	gust 11, 20	008
nT	1	30. Name and address of person of	1	leath (Item 23a	r 11	1 Penn Stree	t, Baltim	nbre, N	/ID 21201			
U	Stat	Tasha Greenberg MD.  31. Date filed (Month, Day, Year)	32. Registra	r's Signature		P.						
Reg		ATTE 1	2 2008	us of	1	Eggs A.						
DUMIN 47 Day	1/200		-	C	RIGIN	IAL						

DHMH 17 Rev 1/2001 OCME 2006

OCME

		•	For State Registrar			iai y iai i	Cei	tificate of	Death		Reg. No	.200	8 2	25872
2) (2)	Physicia	an	1. Decedent's Name (Fin Charles J						•	2. Date of Domestry  Month  July 3		ay 2008 Yea	r	Time of Death 7:15 A M
	/Medic Examin	al	4a. Facility Name (If not Rockspring	institution, give	street and numbe	r)	·	4b. City, Town, o		c. County of De	eath	7.13 11		
- 10	Funeral Director		5. Social Security Numb	er 6. Se		nge (In yrs	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	irs. 8. Date of Bi in. (Month, D 4-27-	irth  ay, Year  -1917			(State or Foreign
lian .	Allen o esperador		Usual Residence of Dec	cedent c. County		10c. Cit	y, Town or Lo	cation					10d. I	nside City Limits
	Maryla -f shov ied at	tor	PA	Luzern	e		Glen L							1 □ Yes 2 No
	3a or 28a st be notif	Funeral Director	10e. Street and Number 15 Arch S			1		10f. Zip Code 186	517		10g. C	itizen of What	Country?	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 3 ☑ Widowed 4 □		12. Was Deceder Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	No.	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ar Black, W Specify:		
0-617	ithin 72 ho ne. nan "natur e Medical E	Completed	15. (Specify o	Decedent's Edu only highest grad ry (0-12)	cation e completed) College (1-4o	r 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire 1 Miner	oation during most of v d)	working		Kind of Busine		ry
Idiiu 21	ld be filed w lental Hygier ked other th ic event, the	To Be Cor	17. Father's Name (Firs				COa	I MINEL	18. Mother's N	Name (First, Middle Studna			Le	
	2 shou and M is mar raumat		19a. Informant's Name/					ng Address (Street					e, Zip Cod	de)
≥ u`	1 and Health em 27		Charles 20a. Method of Dispositi	Wetzel	(son)	20b. F	Place of Dispo	Charlyn	i	Date Date		Location - City	or Town,	State
Daltillor	Pages nent of ant: If II ary or o		1 Burial 2 □Cr 4 □ Donation 5 □				. Alda	matory or other pla berts Cen	n. 8-2	2-08	1	len Lyo		A
סמור	permit. Departr Importa any inju		21. Signature of Funer	Service Livens			6	2. Name and Addre 10 West N	ess of Facility of MacPhail	Schimunek L Road, E	Fur Sel A	neral H Air, MD	ome 210	014
	Physician /Medical	0.00	23a. Part1. Enterthe d shock, or heart fai Immediate Cause (Fina disease or condition resulting in death)	ilure. List only o	ne cause on eacr Coron a.	line.	eart D		ng, such as card	diac or respiratory	arrest,		Ap Inte On	proximate erval Between eset and Death
, o	rificate be executed  by physician and as the burial-transit	Examiner	Sequentially list condition if any, leading to immediate the Cause (Disease or injurthat initiated events resulting in death) Last		D	as a conseq							7-	
O. BOX 66/60,	death ce e attendir d for use	Physician/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?	d	2 Feta at time of c	al death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	y			23d. Date of Month	delivery Day	y Year
ras, r	requires that the een signed by the	by	Part II. Other significar Atrial Fi		_		_						e to the c Probably	ause of death? y 4 muulunknown
Records	The law rec ate has been page 2 shou	Completed	Dementia,	, Pulmon	ary Hype	rtens	ion.			24a. Wa aut per 1□ Yes	topsy formed?	prior	to comple	findings available etion of cause of
vision or vital	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be C	2 Accident	T.	28e. Place of	njury Day Year)		of 28c. Inju	her: 4 ☐ Nursin iry at irk? ] Yes 2 ☐ No	Death (Check only  ig Home 5  Re  28d. Describe  28f. Location	one) sidence e how in	jury occurred		ZIVING
ב	e Hospital o 24 hours aft s Funeral DI etely filled in	Medical Cer	29a, Certifier 1 (Check only 2 one)	Certifying Phy Medical Exam	rsician: To the be iner: On the basi and manner	of examina	owledge, dea ation and/or in	th occurred at the to	ime, date and p opinion, death o	lace, and due to the	ne cause e, date a	e(s) and manne and place, and	r as state due to the	ed. e cause(s)
)	To the vithin To the compl	Me	29b. Signature and title	e of certifier	lang	1.		29c. Licen	se number	87-	29d. [	Pate signed (M	OS	y, Year)
	10		30. Name and address	of person who	ompleted cause of	of death (Ite	m 23a) (Type	Print)	ノ・井ン	47 =	100	1 11	11	MA DIN

Registrar
DHMH 17 Rev 1/2001

State

AUG 1 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 70 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 3–10–1915 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 1 F Months 93 219-23-8809 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 □ No Baltimore n/a 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 819 Sheridan Avenue 21212 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: specifAfrican-American 3√□ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oustodian Supervision Morgan State University 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Neal Charles Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Kahn Drive,Pikesville, MD 21208 Muriel 1. Roberts / Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Menorial. Park 8-13-08 Arbutus, MD 5 Other (Specify) 21. Signatur un si Service Elcen 22. Name and Address of Facility 1 ie Fineral Home P.A. of Baltimore Co.

**Physician** /Medical

Physician /Medical

**Examiner** 

10a, State

MD

Director

Funeral

Completed by

Be

**Funeral** 

Director

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at angles.

Examiner

Examine the burialattending physician for use as the buria Physician/Medical signed by the a þ Completed After this certificate Be Medical Certification; To

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

	116	9200 lib	rty Road, Rand	allstown, MD 2		Delicariote Go.
23a Fair Enter the disease, or come	olications that caused the deat	h. Do not enter the mod	e of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conseq	VIE WOLT	FULLURE			Offset and Death
Sequentially list conditions, in any, searing to infractions cause. Enter Underlying Cause (Disease or injury	b. — Due to (Ur as a nor seq	unitie of):				
that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	il death 3 🗆 Ectopic p			23d. Date of de Month	elivery Day Year
Part II. <b>Other significant conditions</b> c	ontributing to death but not res	ulting in the underlying c	ause given in Part I.			o the cause of death? Probably Unknown
				24a. Was an autopsy performed 1 □ Yes 2	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 💆 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ D0	Other: 4 Nursing	Home 5 ☐ Residence	6 Other (Spe	ecity NOSMLE
27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		28b. Time of Injury M	8c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how in		1
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory	, office	28f. Location (Street City or Town, Sta	a <i>nd Number</i> or Fl ate)	lural Route Number,
	ysician: To the best of my kno niner: On the basis of examina and manner stated.					
29b. Signature and title of certifier		290	. License number	29d.	Date signed (Mon	th, Pay, Year)

100080

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

3. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

NIE MUNEURN FRO HUNST. RUSTON TOWN, M.D.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 AUGUST 5, 20:18 JAMES THOMAS WHITE SR. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BEL AIR UPPER CHESAPEAKE MEDICAL CENTER HARFORD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 17, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours **™** M 2□F 189-16-8160 84 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10g, Citizen of What Country? 10f Zin Code 607 Plumtree Road USA 21015 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Earl White Frances Adelaide Archer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou White / Wife 607 Plumtree Rd., Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery 8-9-08 Bel Air, Maryland 21. Signature of Funeral Reprice Vicenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Fint . Ent if the disease, or complications that caused the disath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn filter. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myseurdial Due to (or as a conse uence of): dronary Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner

Physician

/Medical

**Examiner** 

Director

Funeral

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Completed

Be (

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, AUG 12

29a. Certifier (Check only one)

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

f Health and Mental Hyg Item 27 Is marked other other traumatic event, I

permit. Pages 1
Department of H
Important: If ite
any injury or ott

**Physician** 

hours after death with the Maryland

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical

State

DHMH 17 Rev 1/2001

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<sup>Year)</sup> 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ry!ana /	•	nt of Heal ite of Dea		епіаі ну	/gren Reg. N	2008	25875	õ
	Physici	an	1. Decedent's Name (First, Middle, L			<u></u>			2. Date of De		year C	3. Time of Death	_
	/Medio	cal	Donald Franci 4a. Facility Name (If not institution, g		d	4b. City	y, Town, or Loca	tion of Death	08	<u> </u>	c. County of Death	1 //	
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	Funeral			Sex 7. Age 1X M 2 ☐ F	(In yrs. last bi	rthday) If Und Yrs. Months		nder 24 Hrs. urs Min.	8. Date of Bi	rth ay, <i>Ye</i> a.	9. Birth	place (State or Foreigr ntry)	7
	Director		212-30-2153 Usual Residence of Decedent		76				03/25/	193.		yland	_
	death with the Maryland ms 23a or 28a-f show rmast to cellifud at	'n	10a. State 10b. County		10c. City, Tow							10d. Inside City Limits 1 □Yes 2\n\dagge\dagge\no	
	the M	Director	MD Balti	nore	Kings	sville	ip Code			10g. C	Citizen of What Cou		_
,	th with 23a or	al Di	11605 Cedar La	ne		2	1087			υ	.S.A.		
L.L.	tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dec If Yes, sp	edent of Hispan ecify Cuban, Me	ic Origin? (Spe xican, Puerto I	cify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White,		
036	urs afte	by	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:	)	1 □Yes	2Ã No Sp	ecify:			Specify: Wh	ite	
<b>₹</b>	72 hou 'natur	Completed	15. Decedent's (Specify only highest of	Education grade completed)	168	Decedent's Us (Give kind of w	sual Occupation vork done during use retired)	most of working	ng	16b.	Kind of Business/Ir	dustry	
Warfield, Doratimore, Maryland 2121	within ene. than "	duuc	Elementary/Secondary (0-12)	College (1-4or 5+	)	Steam f			-	Loca	al Union	486	
○ <u>b</u>	al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, La.	st)		Decam I		Mother's Name	(First, Middle			300	
Var Var	ould be Menta larked latic e	To	John Asa Warfie					largare		_			
Mar.	d 2 sh Ith and 17 is m traum		19a. Informant's Name/Relationship  Virginia B. Wa				•				y or Town, State, Zi, Maryland	,	
rf,	ss 1 an of Hea item 2	1 1	20a. Method of Disposition	-		of Disposition (Nature)			ate		Location - City or To		_
2 E	Page ment tant: If lury or		1 Burial 2 Cremation 3 4 Donation 5 Nother (Spec		1	r Memor	ial Gdn	s.08/07	//2008	Bel	Air, Mar	yland	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Extrainer must be reafficed at once.		21. Separatural of Funeral Service Lic	ensee Door h			and Address of I	E.				Home, P.A	١.
		ę ·	23a. Part 1. Enter the disease, or co	mplications that caused t	he death. Do						e, Maryla	Approximate Interval Between	
	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each line	rudis	tress a	nd inch	nittu ol	arria	u o	rotection	Onset and Death	
	/Medical Examiner		resulting in death)	Du to (or as a	corre quence	of):		1000	AND	) '	,	2 00000 100	
	* F	je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):	surger	goni	CCV			21101412	
V	executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C									
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68760	rificate be executed ng physician and as the burial-transit	ledical		d									_
Вох	ath cer ttendin or use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	□ Fetal deat	h 3□Ectopic	pregnancy				23d. Date of deliv	very Day Year	
0.	the deg	Physician/	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (	(specify)				World	Day Tour	
σ.	e law requires that the death cer has been signed by the attendin e 2 should be detached for use	by Ph	Part II. Other significant conditions	contributing to death but	not resulting	in the underlying	cause given in l	Part I.	23e. Did	tobacco	o use contribute to	the cause of death?	
Vital Records,	equire een sig ould b	ted k							1 🗆	Yes	2 No 3 Pro	bably 4 Unknown	
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Ž.	Physician: r this certifica ral director, p	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/C	utpatient 3 🗆 [	Othor				6 ☐ Other (Spec	ify)	
o uc	ling P	ion:	27. May er of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day,	Year) 28b.	Time of Injury M	28c. Injury at Work? 1 □ Yes		28d. Describe	how inj	jury occurred		
Division of	Attending r death. ector: After by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could not	be 280 Place of Injur	y - At home, f	-			28f. Location	(Street	and Number or Rur	al Route Number,	
Δj	tal or rs afte al Dire led in b	Cert	4 Homicide	building, etc.	(Ѕресіту)				City or To	wn, Sta	ate)		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	29a. Certifier 1 ✓ Certifying (Check only one) 2 ✓ Medical Ex	Physician: To the best o aminer: On the basis of and manner stat	examination a	ge, death occurre nd/or investigation	ed at the time, do	ate and place, n, death occurr	and due to the	e cause , date a	e(s) and manner as and place, and due	stated. to the cause(s)	
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner state		2	9c. License num	nber		29d. I	Date signed (Month	, Day, Year)	_
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	I(I)		30. Name and address of person wh	o completed cause of de	ath (Item 23a)		lin Sauc	ing No	Qr.liv	WW	PLIN OI	727	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	11/41/16	11 9400	y C UI.	UMIII	INI	, My 21.	-UT	_
	Registr	rar	111111 1 % 200	O But College	-								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Aurelia Elizabeth Ward 2008 August 4:25 AM /Medical 4a. Facility Name (If not institution, give street and number)
Prince Georges Hospital 4c. Counfy of Death 4b. City, Town, or Location of Death Examiner Prince Georges Cheverly 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** DC Country) Days Hours 1 □ M 2X F 579-30-7299 01/12/1921 Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Prince Georges Seat Pleasant Yes 2 No Director 10g. Citizen of What Country? 101. Zip Cada 400 69th Place USA death v Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyB1ack þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 I and Mental Hygiene.
Is marked other than "nate (Give kind of work done during most of working life. DO NOT use retired)

Domestic elementary/Secondary (0-12) College (1-4or 5+) Self 17. Father's Name (First, Middle, Last)
Albert Norwood 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be Carrie James 2 19a Informant's Name/Relationship (Type. Print) Jean Motley/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4741 Brooks St. NE Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cheltenhem Veteran8/13/2008Cheltenhem, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 20019 21. Signature of Funeral Service Licenses Dunn&Sons 5635 Eads St. NE Washington, DC moll 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Renal Failure Immediate Cause (Final **Physician** 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of): years Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. List of Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Advance Age the death certificate be executed Exami physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 1□ Yes 2 No certificate 2 No 1 ☐ Yes Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral is 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation Injury М 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058213 08/02/08 ause of death (Item 23a) (Type, Print) Greenway Ctr. 30. Name and address of person who completed Farhad Jamali 7525 Dr. Greenbelt MD 20770 32 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 12 State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month **Physician** 7:40Р м August 9, FRANK WILBUR WELSH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE Baltimore County Timonium If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Director 218-26-7716 MARYLAND April 9, 1932 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at Director 1 Yes 2 □ No N/A Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3702 Rexmere Road Funeral 21218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status filed within 72 hours after 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married P 1 ☐Yes 2 ▼No Specify Il Hygiene. other than "natural", ģ White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) County, State & Federal Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: if item 27 is marked other the any Injury or other traumatic and Administrator Governments 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Alexander G. Welsh ဂ္ Helen Lyons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Regina Welsh 3702 Rexmere Road, Baltimore, Maryland 21218 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 □ Other (Specify) Moreland Memorial Park 8/14/2008 Baltimore, Maryland Sign w Yof Funeral Servi 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE RENAL DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of). P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown is certificate has been signed director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐Yes 2**X** No 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Injury at Work? Hospital or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 29c. License number UGUS Ne. 30. Name and address of person who completed cause of death (Item 23a) Type, Print) ERNESTINE WRIGHT 2300 DULANEY WALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of M		ertificate of De			Reg. No.	8 25878
	Physici	an	1. Decedent's Name (First, Midd					Date of Dea     Month		3. Time of Death
J.,	/Medi		ELEANOR		TH	WILKIN		August	6, 200	
	Examir	er	4a. Facility Name (If not institution			4b. City, Town, or Lo	cation of Death		4c. County of	
	Funeral		Greater Balt 5. Social Security Number	6 Cay 7 A	L Center ge (In yrs. last birthda)		Under 24 Hrs.	8. Date of Birtl	Baltimo	Birthplace (State or Foreign Country)
	Director		215-18-6940	1 M 2 M F	M 2 1 P			8. Date of Birtl Month, Day 02/18/	1922	MD MD
	and		Usual Residence of Decedent  10a. State 10b. Count	,	10c. City, Town or L	ocation				10d. Inside City Limits
	the Marylan r 28a-f show	호		TIMORE		LTIMORE				1 □Yes 2 🛣 No
	or 28a	irec	10e. Street and Number	TITIONE		10f. Zip Code			10g. Citizen of Wha	at Country?
	23a c	ralD	7912 STEVENSO	N ROAD		212	208		USA	4
21215-0036	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 🗖 Ma 3 □ Widowed 4 □ Divorce	If Yes Give	Ever in U.S. 13	Was Decedent of Hispa If Yes, specify Cuban, N 1 □ Yes 2 1 No S	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, \ Specify:	American Indian, White, etc. WHITE
15-(	nat	ete	15. Decede (Specify only high	nt's Education est grade completed)	16a. Dec (Giv	edent's Usual Occupatio e kind of work done duri DO NOT use retired)	n ng most of worki	ing	16b. Kind of Busin	ess/Industry
12	be filed within tal Hygiene. St other than event, the Man	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) <i>life</i> .	HOMEMAKER			OWN HO	)ME
	other other	BeC	17. Father's Name (First, Middle		I		. Mother's Name	(First, Middle,	Maiden Surname)	
/lar	uld be Ments arked atic ev	5 E	PHILIP	CHES	LOCK		ROSE		SHIL	_KRAUD
Maryland	2 should be filed w h and Mental Hygie is marked other t raumatic event, th		19a. Informant's Name/Relation			ing Address (Street and			•	
	ges 1 and 2 should tt of Health and Mer If item 27 is marke or other traumatic		BERNARD WILKI 20a. Method of Disposition	NS / HOSBAND		2 STEVENSON		BALIIMO	KE, MD 2 20c. Location - Cit	21208
Baltimore,	oermit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr onge.		1 ٌ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	Specify)	1	osition (Name of matory or other place) E HEBREW	08/10	/2008	REISTERST	TOWN, MD
Bal	permit. Par Departmen Important: any Injury		21. Signature of Funeral Service	Ligengee	-	2. Name and Address on REISTE				)S., INC. _E, MD 21208
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that caused t only one cause on each li	d the death. Do not en	ter the mode of dying, s	such as cardiac o	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. EN	CEPHA	LOPATHY				Onset and Death
7	Examiner		,	Due to (or as	a consequence of):	EFFUSI	2000			
	73	ner	Sequentially list conditions,	b. Due to (or as	a consequence of).	· E// 03/	<i>U1 4 G</i>			~
J	ecutec ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	ERICAL	LDIAL E	FFUSI	0~		
68760,	be exician a	a E	resulting in death) Last	Due to (or as	a consequence of):					
287	ficate physics from the f	Medical I		d						
Box (	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant a	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date o Month	
P.0	at the	Phys	9 Unknown	9 🗆 Unknown						
Records,	equires then signer	ed by	Part II. Other significant conditions and IA C	FIBRIL	=	underlying cause given in	n Part I.			te to the cause of death?  Probably 4 ☐ Unknown
ecc	law re nas be	plet	-	. ,_ ,				24a. Was a	an 24b. Wer	re autopsy findings available r to completion of cause of
E H	: The	Co						perfor	med? dea	th?  Yes 2⊿No
Vital	sician certif rector	Be	25. Was case referred to medica examiner?	Hospital:		Other	i. Place of Death			
ō	y Physer this eral di	5.	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpatie	of 28c. Injury at			ence 6 Other own injury occurred	(Specify)
Ö	ath. rr: Afte	atio	1 Natural 5 □ Pendii 2 □ Accident invest	ng ( <i>Month, Da</i> gation	y, Year) Injury	Work? M 1 ☐ Yes	2 □ No			
Division	al or Atte s after de l Directo	Certification:	3 Suicide 6 Could 4 Homicide determ	not be nined 28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office	:	28f. Location (S City or Tow	treet and Number on, State)	or Rural Route Number,
	ne Hospit n 24 hour ne Funera	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis of and manner st	of examination and/or i	th occurred at the time, nvestigation, in my opinion	date and place, on, death occurr	and due to the deed at the time, o	cause(s) and mann date and place, and	er as stated. due to the cause(s)
_	To the To the Comp	Ĭ	29b. Signature and title of certifie	er .		29c. License nu			29d. Date signed (A	
		į	2. Warra	MD		00608	587		08/07	7/08
	10		30. Name and address of person		leath (Item 23a) (Type	Print)	00.5	2005	n/ 0 n	9/08 AL CENTER
	Sta	te	31. Date filed (Month, Day, Year)	HOMAS A 32 Registr	ar's Signature	EMICIE	1517411	TURE	TCOICE	TL COVIER
	Registr		AUG 1 2	2008	Mr A	and s				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 10, 2008 Year Michael 5:30 P M George Younts 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Pasadena If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) February 13,1964 7670 Colonial Beach Drive Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F 228-17-4336 44 Frankfurt, Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7670 Colonial Beach Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years 2 years Self-Employed Computer Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Ronie Younts Patricia Nolan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Sampson Younts wife 7670 Colonial Beach Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 15. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Of Jesus Cem. Dundalk, MAryland 2008 4 ☐ Donation 5 ☐ Other (Specify) signature of Funeral Service Licensee connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. Enter the disease shock, or heart failure. complications that caused the death only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ocula years disease or condition resulting in death) Due to (or as a consequence of): arlar melanonno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 Tes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 27. Manner of eath Hospital: Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ome 5 Residence 6 □ Other (Specify) 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 1 Natural 5 Pending

Examine be executed burial-transi and requires that the death certificate the the attending p for use as t the signed by t I be detach icate has been si, page 2 should b certificate Physician: director, After this funeral

2 Be

investigation

2008

2

AUG

Physician/Medical Completed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

Be

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1 and 2 should be filed within 72 hours after death with the Maryla Heatth and Mental Hygiene. It was 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Exeminer must be notified at

Department of Health Important: If item 27 any injury or other to

**Physician** 

/Medical

Examiner

injury or

Pages 1

filed within 72 hours after

Maryland 21215-0036

3altimore,

Box 68760.

P.0.

Division of Vital Records,

death with the Maryland

ospital or Attending hours after death. within 24 hours are: co...

To the Funeral Director: A
---arely filled in by the fi To the Hospital

Certification: To 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number D2339 30. Name and address of person who completed cause of death (Item 23a) (Type, Print olfe Street Baltmore UD 21287 600 N. 31. Date filed (Month, Day, Year) 32 Registrar's Signature

1 ☐ Yes 2 ☐ No

State Registrar

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAK-EL

31. Date filed (Month, Day, Year) JUL 3 0 2008

DAVID

D0047711

304-306 North Street Suite #3 ELLTON MARTLAND 21921

29,2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:30 **Physician** July 2008 A M William Earnest Allen, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bayside Care Center St. Mary's Lexington Park 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, August 8, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Florida 220-62-9274 50 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20636 USA 45045 Clarks Mill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) Home Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Earnest Allen, Sr. Geraldine Wilkes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r any injury or other traur 20240 Natures Way, Leonardtown, Maryland 20650 Ethel Marie Halsey / Sister 20a. Method of Disposition
1 □ Burial 24 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory July 29, 2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of u, in , such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Approximate Interval en Onset a Immediate Cause (Final **Physician** month around disease or condition resulting in death) /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a conseque executed burial-trar Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy 1 ☐ Yes 2 🔁 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) e Hospital or Attending P. 24 hours after death. Funeral Director: After t Certification: 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 5 Pending Injury 1 Natura 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24035 Three Notch Road, Hollywood, Maryland 20636 James P. Jarboe, M.D. 31. Date filed (Month, Pay, Year) 32. Registrar's Signature JUL 2 9 2008 Registrar

			101	epartment of Health and N Certificate of Death		iene	LOOOL							
			Decedent's Name (First, Middle, Last)		2. Date of Deal Month	th Day Year	3. Time of Death							
	Physici: /Medic		CHARLES NEWMAN ADAMS,	JR.	July 24,	2008	11:15A M							
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death								
			Fort Washington Hospital	Ft. Washington	1	Prince George								
	Funeral Director		5. Social Security Number  577–50–9300  6. Sex 1 M 2 □ F  7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth 10/8/193	Year) 9. Birthp Cour Tenne	lace (State or Foreign try) SSEE							
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	or Location		1	Od. Inside City Limits							
	Mary -1 eh	ţō	Maryland Prince George Forest He	eights			1 XYes 2 □ No							
	r 28a	Directo	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cour	itry?							
	deeth with the Maryland ms 23a or 28a-f ehow rmat be rigiting at	aiD	109 Onondaga Drive	20745		USA								
	99 E	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,								
21215-0036	be filed within 72 hours after deeth with the Marylar lat hygiene. d other than "natural", or items 33s or 28s-1 show event, ite modical Expoler man be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☒ Yes 2 ☐ No 1961 — If Yes, Give Year or Dates: 1964	1 ☐ Yes 2 ☐ No Specify:		Specify: White								
ည	72 h	etec	15. Decedent's Education 16a. D (Specify only highest grade completed) (0	ecedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	king	16b. Kind of Business/In	dustry							
7	filed within 72 Hygiene. Ither then "natent, it e Marical	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	ife. DO NOT use retired) ense Analyst		Federal Govern	ment							
	Hygie Hygie other		17. Father's Name (First, Middle, Last)			Maiden Surname)								
<u>a</u>		To Be	Charles Newman Adams, Sr.	Willie Ru	th Dillahu	ınty								
Maryland	s 1 and 2 should if Health and Men item 27 ie marke other traumatic			Mailing Address (Street and Number or Rui			Code)							
	and lealth m 27			Onondaga Drive Forest He	-									
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from State  20b. Place of Disposition 20b. Place of Disposition	20c. Location - City or To										
	rtmer rtant		Kalas Crematory 7/27/2008 Edgewater, Maryland  21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home											
ğ	permit. Pages 'Department of the Important: If ite any injury or of once.		In P. Kalas h.	6160 Oxon Hill Rd. Oxon										
	Pnysician /Medical Examiner		23a. Pafr1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of Sequentially list conditions.	yoradial Há	or respiratory arr	etin	Approximate Interval Between Onset and Death							
	ted nsit	nine	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury											
	ad-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of)	):			The same							
8760	icate be execute physicien and s the burial-trans	dicai E	4											
9	tificat ng phy as th	fedi												
O. Box	it the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year							
rds, P	The law requires that ste has been signed b sage 2 should be deta	۵	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		bacco use contribute to t es 2 □ No 3 □ Prot	(V)							
Record	aw re	Completed			24a. Was a	an 24b. Were auto	psy findings available mpletion of cause of							
	The la	E O			autop: perfor 1 Yes	med? prior to co med? death? 2Д No 1 ☐ Yes								
Vital	sician: Th certificete rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only or									
-	Physic this co	မ	1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ☐ ER/Outp			ence 6 Other (Special	ý)							
Division of	uttending F death. ctor: After y the funera	ation:	2 Accident investigation	me of 28c. Injury at work?  M 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred								
Š	or after in bire	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of Injury - At home, farm building, etc. (Specify)		City or Tow									
	0 = V)	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and/and manner stated.	death conumed at the time, date and plene or investigation, in my opinion, death occu	and dua to the or rred at the time, o	ausa(s) and mannar as state and place, and due t	terlad o the cause(s)							
	To the vithin 2 To the comple	Σ	29b. Signature and title of certifier	29c. License number 4604	46	29d. Date signed (Month,	200 g							

State Registrar 31. Date filed (Month, Day, Year) JUL 2 9 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year noreich Basi 18300 M JUL 27 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3405 Spring MonTa SHURY Doner ora Date of Birth (Month, Day, Youne 14, Birthplace (State of Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. <sup>Year)</sup> 1926 **Funeral** 1**⊠** M 2□ F Months Days Hours 579-66-9775 82 **Director** June Argentina Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shore event, the Medical Evan transfer ust be notified at Director 1 ☐Yes 2 No Maryland Montgomery Silver 10e. Street and Number 10g. Citizen of What Country? 3405 Floral Street 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ð If Yes, Give tat Yes 2□No Specify: Argentinian Specify: White 3 k Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University Campus Elementary/Secondary (0-12) College (1-4or 5+) 12 Security Guard Security Pages 1 and 2 should be filed venent of Health and Mental Hygicant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moses Andreichuk Trene Matvichuk မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul M. Andreichuk/Son B221 University Blvd., West, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If ite any Injury or of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State July 30 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the is ease, or complications that caused the intent. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Completed 1 ☐ Yes 2 ☐ No, 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perforn Division of Vital 2 No 1 ☐ Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner?
Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D00428 2008 -mo DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 10 / medical

Registrar
DHMH 17 Rev 1/2001

State

mo oma 32 registrar's Signature

BRECHER.

2008

29

31. Date filed (Month, Day, Year)

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

Month

August

<sup>Day</sup> 2008

4c. County of Death

Calvert

U.S.A.

14. Race - American Indian

Black White etc.

Alexandria, VA

23d. Date of delivery

death? 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of

2□ No

Month

Specify.

3,

1. Decedent's Name (First, Middle, Last)

Joseph

4a. Facility Name (If not institution, give street and number)

William

Bel1

Physician

/Medical

Examiner

o the Hospital or Attending Physician: The law requires that the death certificate be executed Certification: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

25884

3. Time of Death

Birthplace (State or Foreign Country)

Washington, DC

white

commercial construction

Approximate Interval Between Onset and Death

10d. Inside City Limits 1 ☐ Yes 2 🙀 No

8:35 A M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kioumarce Yazdani, MD 2555 Solomons Island Rd., Huntingtown, Maryland 20639

State Registrar

31. Date filed (Month, Day, Year)

mores



8/0/3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	Maryland / Dep Co	partment of P <b>rtificate</b> o		d Mental Hy	giene- \ Reg. No.	000	23003
П	Dhysia		1. Decedent's Name (First, Middle, L	ast)				2. Date of De			3. Time of Death
п	Physici /Medi		Thomas T	• Broo	ks			Month July	Day 27, 200	Year NA	6:30 p <sup>M</sup>
	Examir		4a. Facility Name (If not institution, gi	ve street and number	or)	4b. City, Town	or Location of De			nty of Death	
			Fort Washington	Rehab. Co	enter	Ft. W	ashingto	n	Dref	200 C	
	Funeral		5. Social Security Number 6.	Sex 7. /	Age (In yrs. last birthda	) If Under 1 Yea	r If Under 24 H	Irs. 8. Date of Bir	th .	9. Birth	eorges place (State or Foreign ntry)
	Director		578-01-6289	1 <b>⊠</b> M 2□F	96 Yrs.	Months Day	s Hours M	in. (Month, Da			fret, Md.
	P .		Usual Residence of Decedent					OCL. Z	1911	T Offi.	tiet, Ma.
	ryler	_	10a. State 10b. County		10c. City, Town or I	_ocation					10d. Inside City Limits
	e M	50	Maryland Prince	e Georges	Forest	ville					1 Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	ntry?
	15 wi	ai	8587 Ritchboro 1	Rd.		207	47		Unit	ed Sta	ates
	eep see	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13	. Was Decedent of	Hispanic Origin?	(Specify Yes or No		Race - Ameri	
9	afte or It	F	1 ☐ Never Married 2 ☐ Married	1 Yes 25			ban, Mexican, Pu	erto Hican, etc.)		Black, White,	
21215-0036	within 72 hours after deeth with the Marylend ene. then "natural", or Items 23e or 28e-f show he Mudical Evaminar musi be notified at	d by	3 ₺ Widowed 4 Divorced	Year or Dates	:	1 □ Yes 2 ₩ N	o Specify:		Spe	cify: Blac	ek
,	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	edent's Usual Occ e kind of work don	upation	andrina.	16b. Kind of	Business/In	ndustry
<u>~</u>	ithin	ig I	Elementary/Secondary (0-12)	College (1-4o	lito	DO NOT use retir	ed)	VOIKING			
7	ygier ty	S	8th			Cab Dri	ver		Pri	vate	
힏	be fill d off	Be	17. Father's Name (First, Middle, Las	1)			18. Mother's N	lame (First, Middle			
yla	Men Men arka	2	George B. Brooks				Virgin	nia Harri	son		
Maryland	12 should be filed within and Mental Hygiene. File marked other then "reumatic event, the Men		19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ing Address (Stree	et and Number or	Rural Route Numb	er, City or Tov	vn, State, Zip	Code)
	end salth n 27 ser tr		Anthony E. Brook	s /Son	85	87 Ritchl	ooro Rd.	Forestvi	11e, M	d. 20	747
ore	of Her		20a. Method of Disposition		20b. Place of Disp	osition (Name of smatory or other pi	ace)	Date	20c. Locatio	n - City or To	own, State
Ĕ	Pages nent of H ant: if Ite		1 ABurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci	JRemovai from Stati fy) _	Mt. Oli	vet	8/	/4/2008	Washi	ngton,	D.C.
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylen Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or items 23s or 28a-f show any fijury or other treumatic event, the Mudical Examinat must be notified at ODEs.		21. Signature of Funeral Service Lice	nee	2	22. Name and Add	ress of Facility				
m	89 1 8 8		Ansita. 6	Gared 1	101085	Alexande 5538 Mai	Iboro Por	Rė/Forės	tville	ма	20747
			23a. Part I. Emer the disease, or com	plications that cause	ed the death. Do not er	nter the mode of dy	ing, such as cardi	ac or respiratory a	rrest.	, IId.	Approximate
	Physician		Immediate Cause (Final	one cause on each	line.						Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)		ED DEMENTIA s a consequence of):	<u> </u>					
	Examiner										
		e	Sequentially list conditions, if any, leading to immediate	b. ATHERO Due to (or a	SCLEROTIC ( s a consequence of):	CARDIOVAS	CULAR DI	SEASE			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
<u> </u>	exec in an ial-tr	Exa	resulting in death) Last	C. Due to (or a:	s a consequence of):						
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9		edi		u							
ROX	death certifi e attending ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-					224 5	Date of delive	
ň	death a atte	cia	in the past 12 months?			□Ectopic pregnand □ Other (specify)	у			Aonth	D <b>ay</b> Year
o.	the oy the schee	ys	9 Unknown	9□ Unknown		_ Culti (Specif) _					
7	law requires that the de as been signed by the a 2 should be detached f	Y P	Part II. Dther significant conditions	contributing to death	but not resulting in the u	Inderlying cause a	ven in Part I.	23e. Did to	obacco use co	entribute to th	ne cause of death?
cords,	luires	₽				, , ,					ably 4x Unknown
<u>o</u>	w requir been si should	Completed						-			201
ě	0 - 0	m						24a. Was autop	sy	prior to cor	psy findings available npletion of cause of
	r: Tr								med? 3√E No	death? 1 🗌 Yes	2 No
VITAI	ysician: Th	Be	25. Was case referred to medical examiner?	14				eath (Check only o	ne)		
ō	hys this al dii	ို	1 ☐ Yes 2 No	Hospital: 1   Inpati		N JU DON		Home 5 ☐ Resid	lence 6 🗆 O	ther (Specify	1)
Ĕ	ding F th. After funera	on	27. Manner of Death 1 StNatural 5 ☐ Pending	28a. Date of Inju	ury 28b. Time o	f 28c. Inju	ry at rk?	28d. Describe h	ow injury occi	urred	
SIC	feath for: / the f	cat	2 Accident investigation 3 Suicide 6 Could not b				Yes 2□No				
DIVISION	fter d fred lined n by	ertification:	4 Homicide determined	286. Place of In	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (S City or Tow	itreet and Nun	nber or Rura	l Route Number,
ַ	urs a	ပ									
	Hosp 4 hou Fune ely fil	ca	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam	ysician: To the best	of my knowledge, deat	h occurred at the t	me, date and place	e, and due to the	ause(s) and r	nanner as st	ated.
	he in 2	ed		and manner st	of examination and/or in tated.	vestigation, in my	opinion, death occ	curred at the time, (	ate and place	, and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifier		)/	29c. Licen	se number		29d. Date sign	ed (Month,	Day, Year)
	0		Cic		w	D 42	955	1	uly 29	2009	3
1	2)		30. Name and address of person who	completed cause of	eath (Item 23a) (Type,				5 2 5	, 2000	_
'			Edgar Potter MD	1325 Sout	hern Ave.	S.E. Wasi	hington.	D.C. 200	32		
	Stat	е	31. Date filed (Month, Day, Year) JUL 3 0 2008	32. Registr	rar's Signature						
	Registra	17	11 11 21 V / UUU - A	Made and a Maria							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 48 M **Physician** Byrd, Joseph Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICS PONINSULA REGIONAL MEDICAL If Under 24 Hrs 8. Date of Birth (Month, Day, Yea 3/17/1925 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 F Director 83 218-16-8366 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No Pocomoke City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 908 Walnut Street 21851 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: WWII ð 1 ☐ Yes 2 TXNo Specify Specify: white 72 hours ¥☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Serviceman Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည William R. Byrd, Sr. Laura Witham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winter Quarters Drive, Pocomoke City, MD 21851 Joseph M. Byrd, Jr. (son) permit. Pages 1 a
Department of He
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Episcopal Cemetery 7/28/2008 Pocomoke City, MD 22. Name and Address of Facility. Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 21. Signature of Funeral Solvice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** hows /Medical Due to (or as a consequence of) **Examiner** Panc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed myeloproli and burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown 10 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate perform 1 ☐Yes 2 ☐No Division of Vital 1 ☐ Yes 2 No this certific al director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. No 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Certification: To After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 124 hours after death.

le Funeral Director: Aftetely filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbur BAGTI 13. hates SILVION 31. Date filed (Month, Day, Year) 32. egistrar's Signature State 3 0 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** July 2008 2:45 a M 23 Julia Mae Bright /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges 8616 Dunbrook Lane Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 F **Director** 58 Dec 13 1949 Virginia 578-64-4482 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Prince Georges Laurel 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number USA 20708 8616 Dunbrook Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify. Š 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Bookkeeper Waterworks alth and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patrie E. Carter မ Lewis B. Burton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Hyattsville, MD. 20785 item 27 Andrea R. Bright-Daughter 7201 East Ridge Rd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of Hy
Important: If iter
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7-26-2008 Maryland National Laurel, MD. 22. Name and Address of Facility
Murray Funeral Home 4804 Georgia Ave. N.W. Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) a. Lung Carcinoma /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2⊠ No 2 ER/Outpatient 3 DOA မ 1 Inpatient 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day

Box 68760, certificate be P.0. Division or Vital Records,

72 hours after

filed within Hygiene.

Baltimore, Maryland 21215-0036

Examiner and nding physician signed by the a d be detached for been si should t has o the Hospital or Attending Physithin 24 hours after death.
o the Funeral Director: After this pmpletely filled in by the funeral di Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D23743 July 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Martin D. Weltz,

MD

2008

7525 Greenway Center Dr. Greenbelt, Md

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
			State of Maryland / Department of Health and Mental Hygiene  1 - State  Contificate of Double  2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
			Registrar Certificate of Death Reg. No. 2000 2000
	Physici		1. Decedent's Name (First, Middle, Last)  William E. BROOKS  2. Date of Death  Month  Day  Year  JULY 23 2008 5:08 PM
	/Medio Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
^	LAGIIII		CIVISTA MEDICAL CENTER LA PLATA CHARLES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   9. Birthplace (State or Foreign Country)   Yir Qinia
	Director		Usual Residence of Decedent
	ırylan show	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	hours after death with the Maryland tural", or items 23a or 28a-f show al Evarrier must be notified at	Funeral Director	MD Charles Laplata Pres 2 No
	with t	Ξ	10e. Street and Number 7535 Coach Place 20646 10g. Citizen of What Country?
	death ms 2;	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
9	after or ite		1 Never Married 2 Married 1 Yes 2 No
21215-0036	72 hours after dea "natural", or items u'en Evaniou en	sd by	3 Wildowed 4 Divorced Year or Dates:
15	in 72 in "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  [Second of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  [If DO NOT use retired]
212	e filed within al Hygiene. I other than "	mo.	Elementary/Secondary (0-12) College (1-4or 5+) Parking Lot Manager PVT.
pu	ld be file ental Hy <b>ked oth</b> ic event	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
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Z	ges 1 and 2 should be filed within 72 ho nt of Health and Mental Hygiene. If Item 27 is marked other than "natu or other traumatic event, the Medical		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. April 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ē,	es 1 an of Hea filtem 2		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
m 0	Page nent c ant: If ury or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Sicam Church Com. 8-1-08 Mon + 055, Va.
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other th		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Priday Funeral Service
-	20 = g 0	173	Mulling My Jan 1908 Sussifies in Mitchellulle, MD 20721
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Alway Pyrolation 4 yare from
100	Examiner		Due to (or as a consequence of Sebcis
	P #	ner	Sequentially list conditions, if any, leading to infinediate cause. Einer Underlying Cause (Disease or injury that initiated events  Evel Stage Renal discovery
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Evel Stage Panal discover.  Due to for as a consequence of the control of the co
760,	ires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-transit	cal E	Due to (or as a consequence of):
687	ificate g phys is the	edic	d
Вох	h cert ending use a	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
	Physician: The law requires that the death certificat this certificate has been signed by the attending phyral director, page 2 should be detached for use as th	Physician/Medi	in the past 12 months?  1
P.0	d by the	Phy	9 Li Unknown
ds,	signe d be d	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Wunknown
Records,	ysician: The law requir is certificate has been s director, page 2 should	Completed	
Re	The lay	dwc	24a. Was an autopsy findings available performed death?
of Vital	ian: Trifficat	BeC	25. Was case referred to medical 26. Place of Death (Check only one)
f V	nysic nis ce direc		examiner?  1 Yes 2 No
n o	ding Phi h. After thi funeral	ii o	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Work?  28c. Injury at Work?
Division	I or Attendi after death. Director: A d in by the fu	icati	2 Accident investigation M 1 Yes 2 No
Div	after after Direct	Certification: To	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the He within 24 To the Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many open stated.
	To To con	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	(2)	-	D-006/652 07/23/2008
2	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ATUL KATYAL MD. & POST OFFICE ROAD, SUITE 101, WALDORF, MD 20602
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signal are
	Registra	ar	JUL 2 9 2008 Been & April
DHI	MH 17 Rev 1/20	001	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 8 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month 7/27/2008 12:30 pm Lucille Courchesne Burns 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Prince George's Hyattsville Sacred Heart Home If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 7/13/1918 Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Deys 1□ M 2 F Months 90 Manchester. 003-05-3651 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1⊠Yes 2 □ No MD Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 5805 Queens Chapel Road 20783 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Eugenie Boisvert Adolphe Courchesne 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Celeste B. Sickles, Daughter 5831 Dewey St., Cheverly, MD 20785 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/1/08 Gate of Heaven Cemetery Silver Spring, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 lus 236. Perf.1. Enter the disease, or complications that caused the death. Do not enter the gode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Dnset and Death Immediate Ceuse (Final disease or condition resulting in deeth) 15 Mins. Myocardial Infarction Due to (or es a consequence of): Years Coronary Artery Disease Due to (or es e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed?

1 ☐ Yes 2 ☐ No

July 27, 2008

Physician /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

10e. Stete

Director

Funeral

Completed by

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Martel hygiene. Important: if Item 27 is marked other than "natures", or Items 23a or 28s-1 show eny injury or other traumatic event

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Physician: The law requires that the death certificate be executed filled in by To the Hospital within 24 hours To the Funerel C

Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diverticulosis, Dementia, Urinary Tract Infection Completed by 1 ☐ Yes 2 🖾 No Be 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide edicai 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted. (Check only one) 29d. Date signed (Month, Dey, Yeer) 29c. License number

State Registrar

29b. Signeture and title of certified

30. Neme and eddress of perso Dr. Raman Tuli

31. Dete filed (Month, Dey, Yeer,

JUL 29

2008

3503 Perry St., Suite B, Mt. Rainier, MD 20712 32. Registrar's Signature

who completed ceuse of deeth (Hem 23a) (Type, Print)

9609

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** michael 22 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital None Birthplace (State or Foreign Country) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | April Day (Year) | 1935 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 73 New York **Director** 114-28-0791 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Rockville Maryland Montgomery Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code death with 20852 5922 Edson Lane U. S. A. Funerai 12. Was Decedent Ever in U.S.
Aymed Forces?

14 Yes 2 □ No Army
If Yes, Give
Year or Dates: Reserves permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural". or italingote. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2K No Specify <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Photography Photo Finishing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann Zukofsky Maxwell Barrett ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 5922 Edson Lane, Rockville, Maryland 20852 19a. Informant's Name/Relationship (Type. Print) Fanny Barrett - Wife 20b. Place of Disposition (Name of cemetery, cremator, or other place)
Carden of Remembrance
Memorial Park 20c. Location - City or Town, State 20a, Method of Disposition ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Maryland 20852 Sonald tottlemyer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as | consequence of): Physician /Medical Examiner Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Pancreatic Cancer attending physician and for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month in the past 12 months? Day 4 Pregnant at time of death ate has been signed by the air page 2 should be detached to Tyes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 ☐NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 L NO 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of Injury (Month, Day Year) 27. Manner Death 1 atural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 5 Pending investigation 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 2 9

Janice

, Medical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leung

32 Registrar's Signature

29c. License number

Res -000

29d. Date signed (Month. Dav. Year)

600 North Wolfe St, Baltimore, MD, 21287

July 22, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8 perFH, G884, 10/15/08, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 1855 Joel Laverne Burdin 7/22/2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Shady Grove Adventist Hospital Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth A (Month, Day, Year) Min. 1<del>√</del> M 2□ F Months Days Hours 379-30-3088 1930 Michigan Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 1 ☐ Yes 2 ☑ No Florida Duva1 Jacksonville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4073 Alesburg Drive 32224 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married <sub>Specify:</sub>White 1 □Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martin Burdin Archie Myrtle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Burdin-Son 3201 Sweet Meadow Court, Oakton, VA 22124 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Ft. Lincoln Crematory 7/28/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licens 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Arrest disease or condition resulting in death) Due to (or es a consequence of): Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? 1 □Yes ZANo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XX No IXXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065505

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

Division of Vital Records, P.O. Box 68760,

State Registrar

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Physician/Medical

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Be Completed

Medical Certification: To

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 20... any injury or other traumatic event, the Market and Once.

**Physician** 

/Medical

Examiner

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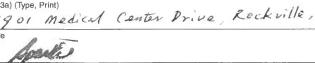
QIUFANG 31. Date filed (Month, Day, Year)

JUL 2 9 2008



M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



23,2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar	Certificate of Death							0. D-1(D	Reg. No	2000			
i ga	Physici /Medic		1. Decedent's Name (First, Middle JAMES DUDLEY					2. Date of D		<sup>y</sup> 2008 Year	3. Time of 1:10					
	Examin	er	4a. Facility Name (If not institutio NATIONAL INST		, Town, or ETHES		of Death		4c.	County of Deat MONTGOM						
	Funeral Director		5. Social Security Number 435-84-7361	6. Sex 1 🔀 M 2 🗆 F	7. Age (In y	rs. last birthd Yrs	ay) If Unde	er 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bi Month, D 8 / 18 / 1	rth av Year)	9. Birti Co. CA	nplace (State or untry)	r Foreign	
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	Maryla -f shov ied at	tor		Feliciana Parish	1	City, Town or Fran		16						10d. Inside Cit 1 ☐ Yes		
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	h with	<u>=</u>	4897 Rosemound	Loop			-   <del>,</del>	0775				US	SA			
	deat	ner	11. Marital Status	12. Was Dec Armed Fo	edent Ever in	U.S. 1	3. Was Dec	edent of Hi	spanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - Ame			
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land	id be i ental ked o	To Be	Joseph Herber	,							Emma					
ary	shou and M mar	F	19a. Informant's Name/Relations			19b. M	ailing Addres	s (Street a	~	_			or Town, State, Z	ip Code)		
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Baltimore, Maryland 21215-0036	ges 1 g of He if item or othe		20a. Method of Disposition 1XI Burial 2 ☐ Cremation	3 XRemoval from	State D	p. Place of Di cemetery, o abenho	sposition (Na crematory or	me of other place	9)	С	Date	20c. Lo	ocation - City or	Town, State		
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Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Marshall's Funeral 4217 9th Street, NW Washington, I										ome 20011			
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												veen	
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38760,	icate be executed physician and s the burial-transit	dical		Cel	Coll Cancinoma							6 46	9/15.			
. Box 6	The law requires that the death certific tte has been signed by the attending p vage 2 should be detached for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	3 □Ectopic pregnancy						23d. Date of delivery						
о. П	ires that the dea signed by the att	Physician/M	1								Month Day Year					
<b>T</b> .	s that ned by e deta		Part II. Other significant condition	ons contributing to d	eath but not r	esulting in the	underlying	cause give	n in Part I.		23e. Did	tobacco ı	use contribute to	the cause of de	eath?	
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Division or	th. : After s funera	tion	27. Manner of Death 28a. Date of Injury Injury 28b. Time of Sec. Injury at Work? 2 Accident investigation 28b. Time of Injury Injury M 1 Yes 2 No													
N N	I or Attendater death	Certification:	2 Suicide 6 Could not be							28f. Location (Street and Number or Rural Route Number,						
	spital or ours afte leral Dir filled in	Cert	4   Homicide building, etc. (Specify) City or Town, State)													
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification completely filled in by the funeral director, to completely filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director is the funeral director.	Medical	29a. Certifier (Check only one)	g Physician: To the Examiner: On the b and man	best of my kasis of exam ner stated.	nowledge, de ination and/o	eath occurred r investigatio	d at the tim n, in my op	e, date an pinion, dea	d place, th occurr	and due to the ed at the time	cause(s , date and	) and manner as d place, and due	stated. to the cause(s)	)	
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	1		Dar	de 1	(J. )	1		00048	201 (	(MD)		0	7-25	-200	8	
			30. Name and address of person RICHARD W. CH			em 23a) (Typ		CENT	ER D	RIVE	, ВЕТН	ESDA -	MARYLA	ND 2089	2	
	Sta	te	31. Date filed (Month, Day, Year)	32.	egistrar's Sig	# .										
	Registr	ar	JUL 29	2008	WELLOW.	15. 1	parte									

		•	For State Registrer	ate of Maryland / Dep Ce	partment of Healertificate of Dea	ath	Reg. No. 2008	3 25893			
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Hortense		Baker	2. Date of D Month July	17 2008				
1	Examin Funeral Director		4a. Facility Name (If not institution, give street  The Johns Hopkins Hospi  5. Social Security Number  225-52-0220  6. Sex 1 □ M	7. Age (In yrs. last birthda			4c. County of Deat Baltimore inth lay, Year) 34				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 Never Married 2 Married 1	n Rd.	SVII1e  10f. Zip-Code  22943 3. Was Decedent of Hispan If Yes, specify Cuban, Mo	nic Origin? (Specify Yes or N exican, Puerto Rican, etc.) pecify:		nerican Indian,			
	ould be filed within 72 hour Mental Hygiene. arked other than "natural" atic event, the Medical Ex	To Be Completed t	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) Con 10th On 17. Father's Name (First, Middle, Last)  John Butler Carey	16a. Dec (Gir Illege (1-4 or 5+)			16b. Kind of Business  Health  Je, Maiden Sumame)  ter Carey	/Industry			
Baltimore, Mar	permit. Pages 1 and 2 shi Department of Health and Important: If Item 27 Is m any Injury or other traum		19a. Informant's Name/Relationship (Type. Preddie M. Baker / 20a. Method of Disposition  1  Burial 2 □ Cremation 3 X Remove 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Son 162  al from State 20b. Place of Discemetery, c Chestnu	20 Taylor Ave sposition (Name of rematory or other place) tt Grove Cem. 22 Name and Address of 18 E. Church Satchell's	July 28,'08 Facility Street, Funeral Serv	gton, MD 20 20c.Location - City or Barboursvil	744 Town, State Lle, Virginia			
	Physician bhysician and bhysician and bhysician and street bruial-transit	cal Examiner	23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
Division of Vital Records, P.O. Box 6	v requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Onknown  Part II. Other significant conditions contribu	23d. Date of de Month	Day Year						
	stetan: The law requires th certificate has been signed irector, page 2 should be d	Be Completed by	25. Was case referred to medical		26.	1 [ 24a. Wa aut	yes 2 No 3 P  s an opsy prior to death? 2 2 No 1 Yes	utopsy findings available completion of cause of			
	or Attending after death. Director: After In by the fune	Certification: To	27. Manne of Death Natural 2 Accident 3 Suicide 4 Homicide  28. Pending investigation 6 Could not be determined	ia. Date of Injury (Month, Day Year)  2 EH/Outpat Injury (Month, Day Year)  28b. Time Injury Injury ie. Place of injury - At home, farm, building, etc. (Specify)	e of try M 28c. Injury at Work? 1 Tyss street, factory, office	of 28c. Injury at Work?  M 1 Yes 2 No					
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	(check only one) 2   Medical Examiner:  29b. Signature and title of certifier  M. Al-Marili	n: To the best of my knowledge, de On the basis of examination and/or and manner stated.	r investigation, in my opinio	on, death occurred at the time	29d. Date signed (Mon	ue to the cause(s)			
	Sta Regist		30. Name and address of person who complete (MOHANNE)  31. Date filed (Month, Day, Year)  JUL 2 9 2008	AL-ZOUBAID  Registrar's Signature	DE, PRINT)	600 North W	olfe St, Baltim	ore, MD, 21287			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician**  $P^{M}$ Evangeline Marie Crunkleton August 2008 7:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 16824 Virginia Ave. Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🖸 F Director 218-03-6788 100 1908 March 9, Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits show Examiner must be notified at 1 ☐ Yes 2 No Director MD Washington Hagerstown 23a or 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16824 Virginia Ave. Funeral 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married jo. 1 ☐ Yes 2X No Specify. þ Specify: 3 ₩ Widowed 4 Divorced White 'natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Communications is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John E. Walters Ethel Cleusman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: If item 27 is Susan C. Parks/Granddaughter 10820 Oak Forrest Dr., Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State in)ury 4 Donation 5 Dother (Specify) Rest Haven Cemetery 8/7/2008 Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD ns that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, use on each line. 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic OBSTRUCTIVE DISEASE PULMONARY **Physician** 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ STENOSIS AORTK 2 No 3 Probably 4 ☐Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? 1∐ Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 20 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient P 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 24 within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Pao 08 10051262 1 ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAO m.D 3 Byrkit Drive, Williamsport, MD 21795 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

Sil

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Florence E. Christian  $P^{M}$ July 22, 2008 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 💢 F Months Days Hours 234-42-7922 84 Director June 17,1924 Virginia Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2X No Anne Arundel MD Odenton 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with t and Mental Hygiene. is marked other than "natural", or items 23a or 2 8615 Wandering Fox Trail Unit 206 21113 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>ک</u> Specify: White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 5+ 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lipiny or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Frank Ernest Elam Effie Elaine Hupp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie C. Merchant/Daughter 5926 Tyler Road Deale, Maryland 20751 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation \_5 ☐ Other (Specify) 7-31-2008 Cheltenham, Maryland Maryland Veterans Cem. 21. Signature of Fune al Service Licenses 22. Name and Address of Facility Beall Funeral Home 5 6512 NW Crain Hwy Bowie MD 20715 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as cause on each line. 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final OVARIAN **Physician** CANCES disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami burial-transi Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by t the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1€Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the 1 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. DC6658 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State

Registrar

medical

2001

32. Registrar's Signature

ABRAHAM

31. Date filed (Month, Day, Year)

JUL 2 8 2008

For kway

21401

08-05765 Ellie Marie Cantrell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 25896

		l- For State Registrar		_		Certific	ate of	Death					Reg. No	D.		
Physicia	n/	1. Decedent's Name (First, Mi	ddle,Last									2. Date of De Month	Day	Yea	г	3. Time of Death 0751 hrs
Medical Examin		Ellie Marie  4a. Facility Name (if not institu		antrel			[a	b. City, To	wn or L	ocation of	f Death	July 28,		1c. County o	of Death	
O 10.		20552 Spring Hill R		Street and In	diliber)			Lexing			Douil			St. Mary		
Funeral		5. Social Security Number	6. Se:	(	7. Age (In	yrs. last bir	rthday)	If Under		If Under		8. Date of I	Birth(MN	M/DD/YYYY	9. Bir Foreig	thplace (State or
Director		213-78-4773	1	м 2 <sup>Х</sup> F		48	Yrs.	Months	Days	Hours	Min.	03/09	1/19	60	Co	untry) <mark>Maryland</mark>
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/Medical	-	failure. List only one cause on each line.  Immediate Cause (Final disease a. Morphine intoxication  Between Onset and Death														
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Box 687 e death certifi- the attending ed for use as t	sici	1 Yes 2 No 9 🗸	Unknown		nant at time	of death	5 Oth	ner (Speci	fy)				- 1			
O. B. t the de by the ached f	Physiciar	Part II. Other significant cor				t not resulting	ng in the u	nderlying o	cause giv	ven in Pa	rt I.	23e. Did	d tobacc	co use contr	ibute to	the cause of death?
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		Pamela E. Southall		Assistant				1 Penn	Street,	Baltim	ore, N	/ID 21201				
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ľ	Physici /Medic		1. Decedent's Name (First, Middle, Rita	Joan		(	Conner	s			2. Date of De Month July 1	ath	Day Year 2008	3. Time of Death 11:52p M
,	Examir		4a. Facility Name (If not institution, §	Lane				yds	ocation of		July 1		c. County of Death	h
	Funeral Director		5. Social Security Number 6 212-44-6130  Usual Residence of Decedent	. Sex 7. A	Age (In yrs. last birt	hday) . Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Sept. 2	ay, Yea	9. Birth Cod 1945 Lou	nplace (State or Foreign untry) isiana
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	0 0 5	To Be C	17. Father's Name (First, Middle, La  Reid Je  19a. Informant's Name/Relationship	fferies				1	8. Mother	's Name	First, Middle, Eugeni	а		
	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic enones.		Michael Conners  20a. Method of Disposition  1□ Burial 2 ☑ Cremation 3	/ Spouse	20b. Place of	18	Truff	le I	ane,		ds, MD	20		
Baltimor	permit. Pag Departmen Important: any Injury once.		4 □ Donation 5 □ Other (Special Signature of Funeral Septice Lice	cify)	Ft. Lir	22.	Name and	Address	of Facility	Si	mple T	rib	entwood, ute e, MD 208	
,	Physician /Medical Examiner	Examiner	shock, or heart failure. Lift only one cause on each line.  Interval Betwoer Chical disease or condition resulting in death)  a. Metastatic Melanoma  Due to (or as a consequence of):  Sequentially list conditions  b.										Approximate Interval Between Onset and Death 4 years	
OX 00/00,	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dical	Due to (or as a consequence of):  d.  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery										very	
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5	ing Physicia After this cer uneral direct	To B	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpati	ient 2 ER/Outpury 28b. Tin		28c.	Other: Injury a Work?	4□ Nurs	sing Hom	Check only one 5 🖾 Resident Describe h	dence	6 ☐ Other (Specury occurred	ify)
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:	the Hospit in 24 hour the Funera	edical	29a. Certifier 1 ★ Certifying F  (Check only one) 2 ★ Medical Exe	Physician: To the best eminer: On the basis and manner s	of examination and	death /or inve	occurred at estigation, in	the time my opir	, date and nion, death	l place, ar	d due to the	cause( date ar	(s) and manner as nd place, and due t	stated. to the cause(s)
ı	3	Σ	29b. Signature and title of certifier	<b>S</b>	MO		Ε	3840					ate signed (Month,	
			30. Name and address of person was William Sharfman 31. Date filed (Month, Day, Year)	n, M.D.	death (Item 23a) (T $10753~{ m Fa1}$ rar's Signature			#415	; Lu	therv	ville,	MD	21093	
	Stat Registra		JUL 2 9 2	008	rars Signature	103	de							

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . Day 2008 August 6, **Physician** 6:25 AM M Harry Greenwood Durant, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Braddock Heights Vindobona Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | NoV. 13, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ty∑M 2□F Months Alabama 421-26-3488 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b County 1 ☐ Yes 2 No Frederick Director Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21703 U.S.A. 5820 Genesis Lane, Apt. 501 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1\overline{\text{TY}}\text{Yes} 2 \overline{\text{N}}\text{No} If Yes, Give 104.6...1 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1946-1948 1 ☐ Yes 2√ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) a Technician/Repairs Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Harry Greenwood Durant, Sr. Lillian Charlton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 904 Junior Street, Alexandria, VA 22301 Andrew G. Durant, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Cemetery Aug. 11, 2008 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preuminia **Physician** disease or condition resulting in death) /Medical YEARS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performe 1 ☐ Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ∏ No after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DOOG 1223 August 6, 2008 me and address of person who completed cause of death (Item 23a) (Type, Print) 196 TJ Drive Frederick, MD 21702 PRAYEEN BILMUM MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Durant Clarence 07 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S PINEVIEW NURSING HOME CLINTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) WASHINGTON, DC 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 X M 2 ☐ F Months Days Hours Director 577-54-1189 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County s 23a or 28a-f short 1XYes 2 No Director PRINCE GEORGE'S CLINTON MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20735 8901 DANGERFIELD PLACE by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceus... Armed Forces? Yes 2 XNo 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ò If Yes, Give Year or Dates: 1 ☐ Yes 2 X No BLACK Baltimore, Maryland 21215-0036 Specify. Specify 3 Widowed 4 Divorced 'natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SECURITY OFFICER PRIVATE 12th ulth and Mental Hygi 27 is marked other r traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ESTHER LATSON DURANT TROY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tranonce. # 1 WASHINGTON, DC 20020 2635 JASPER ST. S.E. KAREN DURANT/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 18/2/2008 RIVERDALE, MARYLAND RIVERDALE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the dise st. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) -CELLT **Physician** hronic /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) P.0. signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 s autopsy performe 2 X No Dealetes mellitus 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 🗆 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 07-83-2008

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD 7801 OLD BRANCH AVE SUITE 409 CLINTON, MARYLAND 20735 PISHDAD

BAHRAM 32. Registrar's Signature 31. Date filed (Month, Day, Year)

2008

**ORIGINAL** 

D 51520

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25901 Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Day Year **Physician** ROBERT Ε. FRITSCHE 3:18 P 2008 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9/9/1937 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral Days Year) Hours Months 212-36-4381 70 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ntal Hygiene. ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director PA York Fawn Grove 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 576 Mt. Olivet Church Road 17321 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Tyes 2 No
If Yes, Give
Year or Dates: 1961-63 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 XNo Specify. Specify: White 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Manufacturing and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Marie Wessel injury or other traumatic ပ Carl Fritsche 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau Valerie Torbert/Pers. Rep. 328 Gemmill Road, Delta, PA 17314 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Crem. 8/9/2008 Leola, PA 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Morele Harkins Funeral Home, Inc., Delta, PA 17314 23a. Part 1 Enter the disease, or complications that caused the death. Do not inter the mode of dying, such as pardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hon disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Dunknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ö Hospital \*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

State Registrar

AUG 1 2 2008

31. Date filed (Month, Day,



Upper

52

32. Registrar's Signature

ORIGINAL

resapeate Dr. Snite

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of			giene Reg. No.20(	18	25902
	Physic		1. Decedent's Name (First, Middle, La:	st)	FINGAL			2. Date of Dea Month	th	Year	3. Time of Death <b>5:30</b> A M
-	/Medi Examii		4a. Facility Name (If not institution, giv 3647 COUSINS DRIV	e street and number)	TINOAL	4b. City. Town	or Location of De		4c County PRINCE		
	Funeral Director		346-44-1145 Usual Residence of Decedent	□M 2DxF	o (In yrs. last birthday 7 Yrs.	Months Day			9. Birthplace (State or Country) 4 1941 GUYANA, S.		NA, S.A.
	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Model Everities in 14th to motify of a	al Director	MD PRINCE G  10e. Street and Number  3647 COUSINS DRIV		GLENARD		4	1	0g. Citizen of Wh		0d. Inside City Limits  1  Yes 2  No  try?
-0036	72 hours after death w "natural", or items 23a	ed by Funeral	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed	12. Was Decedent E Armed Forces? 1	lo	1 □Yes 2 🙀 N	Specify:	(Specify Yes or No- orto Rican, etc.)	14. Race Black, Specify:	A	
nd 21215-0036	should be filed within 72 nd Mental Hygiene. marked other than "na matlc event, the Medic	Be Completed	(Specify only highest gra  Elementary/Secondary (0-12)  12th  17. Father's Name (First, Middle, Last)	de completed)  College (1-4or 5-	(Give	dent's Usual Occ kind of work don DO NOT use retir	e during most of w ed)	orking ame (First, Middle, I	PRIVAT	PRIVATE	
ylar	should be f and Mental i s marked or umatic eve	10 B	JOHN FINGAL		·		ISA	A EDWARDS	3		
Mai	12 shall		19a. Informant's Name/Relationship (7 COLLEEN DUGGAN/SI	,				Rural Route Number			
Baltimore, Maryland	e e f		20a. Method of Disposition  1₺ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Dispo cemetery, cree GATE OF		ace) CEME 8/2		20c. Location - C	•	wn, State
Balt	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Licens	DERICK	7	2. Name and Add	OVER ROAL	J. B. JEN D LANDOVE	R, MARYL		
Ĺ	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or compositors, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to mine diate cause. Enter Underlying Cause (Disease or injury that initiated events.	ac or respiratory arro	est,		Approximate Interval Between Onset and Death				
O. Box 68760,	e dearn certificate be executed the attending physician and led for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a  d.  23c. If yes, outcome of the control of the co	Fetal death 3	] Ectopic pregnan	су		23d. Date o		ry Day Year
rds, P.O.	inres mai me de signed by the a ld be detached f	ģ	9 ☐ Unknown  Part II. Other significant conditions co		not resulting in the ur	nderlying cause gi	ven in Part I.	23e. Did tob	v		e cause of death?
tal Records,		e Completed	25. Was case referred to medical						24b. We / pric dea 2 No 1	re autop r to com th?	sy findings available pletion of cause of 2 ☑ No
Division of Vital	eath.  or: After this cer the funeral direct	Certification: To Be	examiner? 1	tospital: 1 ☐ Inpatien  28a. Date of Injury (Month, Day,	t 2 ER/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 🗆 Nursing I	ath (Check only one Home 5 X Reside 28d. Describe hor	nce 6 Other	(Specify)	,
Divi	3 5 5 1		3 Suicide 6 Could not be determined		y - At home, farm, stre (Specify)			28f. Location (Str City or Town,	State)		
Hod	n 24 hc	edical	29a. Certifier 1\(\mathbb{K}\) Certifying Phy (Check only one) 2	sician: To the best of ner: On the basis of and manner state	my knowledge, death examination and/or inved.	occurred at the trestigation, in my	ime, date and plac opinion, death occ	e, and due to the ca urred at the time, da	iuse(s) and mann te and place, and	er as sta due to t	ited. the cause(s)
12	To the		29b. Signature and title of certifier	L		29c. Licens			d. Date signed (A		
D	A		30. Name and address of person who co		th (Item 23a) (Type, F	D47	604		JULY 29,	200	8
バー	0		SOBHAN A. MATHEWS	M.D. 3048	MITCHELL		AD BOWIE	, MARYLAN	20716		
	Stat Registra	•		32. Registrar	s Signature						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Sidney Gore, 2008 July 21. 8:20 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6013 Belwood Street District Heights Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 1950 9. Birthplece (State or Foreign Country) **Funeral** Days 57 Director 237-84-4336 September 14, North Carolina Usual Residence of Decedent r 28a-f show notified at 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Directo Prince Georges Maryland District Heights with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours after death with th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 6013 Belwood Street 20747 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) M and B Trucking Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Services 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sidney Gore, Sr. Patsy Henry ၉ 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 Item 27 other tr Joy Theresa Elaine Simms-Gore 6013 Belwood Street; District Heights, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Iter
any Injury or oth 20c. Location - City or Town, State July 25,2008 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Spegify) George Washington Cemetery Adelphi, Maryland ignature of Feeral Servic name and Address of Facility
N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Colon Cancer to Liver 10 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of) Examiner as the burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, ıding physician certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. I signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 has autopsy certificate 1□ Yes 2X No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Attending 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide ö To the Hospitai within 24 hours a 29a Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) atilda D26250 July 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matilda H. So, M.D.; 1221 Merchantile Lane; Largo, Maryland 20774 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 27, 2008 6:59 P Helen. D. Garden /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth
July 15, 1914 Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 XX 94 578-28-9128 Washington, DC **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Prince George's Hillcrest Heights Director Marvland 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 3312 25th Avenue 20748 USA Funeral filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Never Married 2 Married 1 ∐ Yes 2X0X If Yes, Give Year or Dates: 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 2KKNo þ Specify. 3 Widowed 4 Divorced White Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Auditor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be ealth and Mental Arthur  $C_{-}$ Garden Margaret Herbert 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau S Denise Hurd / Niece 10523 Hollybrook Drive Charlotte, North Carolina 28277 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 08/02/2008 Washington, DC Congressional Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 14 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2★No 23d. Date of delivery 1 ☐ Live birth for ( 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by the betack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed The law 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2XX No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No Hospital: 1XX Inpatient 2 ER/Outpatient 3 DOA lospital or Attending Physic hours after death.

uneral Director: After this by filled in by the funeral di 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation XX Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

To the Hosp within 24 hou To the Fune completely fil	Medical
cf (10)	
Sta Registi	

30. Name and address of p n who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day,

29a. Certifier

29b. Signature and title of certifie

1EXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

08-05623 John Glodeck

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Dia	ack indelible ink.	Elisure All Co	hies vie rea
State of Maryland /	Department of He	ealth and Menta	l Hygiene

hn Glodeck	State of Maryland / Department of Hea	th	eg. No. 2008 2500								
Physician/		2. Date of Dea Month	th S. Time of Deeth One								
ledical Examinei		Month July 23, 2 Town, or Location of Death	4c. County of Death								
		Burnie	Anne Arundel								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11 Mon 2 F 38 Yrs.	ho Davo Hours Min	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland								
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits								
	MD Calvert County Prince Frede		1 Yes 2 X No								
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 10f. 2		10g. Citizen of What Country?								
ith the 23a or notific	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece	0678	U.S.A. o- 14. Race - American Indian, Black,								
or items 23	1 Never Married 2 X Married Armed Forces?  No Service Armed Forces?  No Service Armed Forces?  No Service Armed Forces?	cify Cuban, Mexican, Puerto Rican, etc.)	White, etc.								
ral", or	or Dates:	2 X No specify: al Occupation (Give kind of work done	Specify: White								
"natur		orking life. DO NOT use retired)	Tob. Kind of Business/mousey								
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examine Completed by	12 Carpent		Local Union #491								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	(1.1 atter 3 Harrie (1.16), History, 2007)	18 Mother's Name (First, Middle,  Joann B. Rem									
2121 uld be fi Mental marked c event,	JOHN W. GLOGECK	ss (Street and Number or Rural Route Nu									
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. (ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other tranmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Donna Glodeck (Wife) 4475 Woo	dview Lane, Prince	Frederick, MD 20678    20c. Location - City or Town, State								
	1 Burial 2 X Cremation 3 Removal from State crematory or other pla	July 27,									
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Specific Lee Cremato 21. Signature of Jacobs Service 22. Name a	ry 2008  nd Address of Facility Lee Funer	Clinton, Maryland al Home Calvert, P.A.								
Bal perm Depa Impo injur	Michael 8125	Southern Maryland B	lvd., Owings, MD 20736								
Physician	failure. List only one cause on each line.										
'medical .aminer	Immediate Cause (Final disease or condition resulting in death)  a. Cardiac Tamponade  Due to (or as a consequence of):		Death								
*	Sequentially list conditions.										
iner	if any, leading to immediate  cause. Enter Undarying Cause  c. Hypertensive Cardiovascular Disease										
ted misit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
60, tre be executed systician and burial - transit											
760, cate be physici he buri	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery								
Box 68760, edeath certificate be the attending physical for use as the bur	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal decedent past 12 months? 4 Pregnant at time of death 5 Other (\$600)		y Month Day Year								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Contribution Contribution of the pure of t	1 Yes 2 No 9 Unknown g Unknown	and the second process of the second process	tobacco use contribute to the cause of death?								
P.O. B es that the d gened by the detached			res 2 No 3 Probably 4 Unknown								
ords, P		24a. Wa									
Records, I The law requires ficate has been sig page 2 should be		pei	prior to completion of cause of death?  s 2 No 1  Yes 2 No								
Division of Vital Records, rad or Attending Physician: The law requirers after death all birectors. After this certificate has been sited in by the funeral director, page 2 should be attituded.		26 Place of Death (Check only one)									
F Vita	1 ✓ Yes 2 No	DOA Other Nursing Home 5  28c. Injury at Work? 28d. Describ	Residence 6 Other:								
nding Plub Inding	27. Manner of Death 28b. Time of Injury (Month, Day,Year) 28b. Time of Injury	1 Yes 2 No	io non injury occasion								
Division of spital or Attending lours after death neral Director: After filled in by the functions of the filled in by the functions of the fu	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac		n (Street and Number or Rural Route Number, City								
Div spital o	4 Homicide determined (Specify)										
Division of  To the Hospital or Attending Ph within 24 hours after death  To the Funeral Director: completely filled in by the funeral		the time, date and place, and due to the ca my opinion, death occurred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)								
To To with To com	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
	Carol Hallan	O.C.M.E.	July 23, 2008								
lew 5	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street	et, Baltimore, MD 21201									
RW > Star	20 Patietraria Signatura										
Registra	TUL & D 2000 CONTRACTOR APPENDI										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day William C. Husfelt July 28, 11:00 P<sup>M</sup> 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 19 Norman Allen Street Elkton Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/20/1925 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland Months 218-18-0037 1X M 2 □ F 83 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Cecil Elkton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Norman Allen Street USA 21921 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Ves 2 No If Yes, Give 1942 Year or Dates: 19 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Husfelt Margaret Leader 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Norman Allen Street, Elkton, MD Edith Nell Husfelt / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State United Crematory or other place)
Services 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 07/30/2008 Newark, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702 toun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition orona resulting in death) Due to (or as a consequence of); Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

**Funeral** 

Director

"natural", or items 23a or edical Examiner must be

the Medical

with the Maryland r 28a-f show notified at

filed within 72 hours after

1 and 2 should be Health and Mental

Is marked

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

21215-0036

Maryland

Baltimore,

The law requires that the death certificate be executed

sician and burial-tran attending physician as the nse for ned by the a signed by should page 2 s this certificate funeral director. After death the

Division or Vital Records, P.O. Box 68760

or Attending Physician:

Hospital

To the

within 24 hours after death To the Funeral Director: filled in by Medical completely State

Registrar

Examiner by Physician/Medical Completed Be Certification: To

25. Was case referred to medical examiner' No No 1 ☐ Yes 27. Manner of Death 1 Natural 2 ☐ Accident

3 ☐ Suicide

29a. Certifier

29b. Signature

4 Homicide

(Check only one)

5 Pending investigation 6 ☐ Could not be determined

and title of certifier

JUL 3 0 2008

Hospital: 1 🔲 Inpatient 28a. Date of Injury

(Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3□ DOA 28b. Time of

28c. Injury at

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

26. Place of Death (Check only one)

autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

death? 1 ∐Yes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion death. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print

mor a 31. Date filed (Month, Day, Year)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Amended#1perMD FCHD, KS 7/29/08 State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 10.55 AM **Physician** Margaret Eleanor Hargett 2008 /Medical County of Death 4b, City, Town, or Location of Death cility Name If not institution, give street and p Examiner MG Kocker le Lutheran ational toch Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 17, 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖼 F 79.05. 96 1912 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be nutified at 1 ☐ Yes 2 X No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 9701 Veirs Drive 20850 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Clerical U.S. Government 12 Health and Mentat Hygidem 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Fenton Hargett E11a May Derr 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and : Department of Health Important: If item 27 any injury or other tra once. Post Office Box 646, Janet L. Hargett - Niece Riverdale, Maryland 20738 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Neelsville Cemetery July 30, 2008 Germantown, Maryland 5 Other (Specify) 4 Donation 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signa ure of F neral Service Licer Kovert 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 100 cons disease or condition resulting in death) /Medical Que to (or es a conse uence of): Examiner vare Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed y physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy 2 No 1 ☐ Yes 2 ☐ No 1 □Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this eral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) 26033 Ridge Road, 20872 Charles W. Karesh M.D. Damascus, Maryland 31. Date filed (Month, Day, Year) 32. Registrans Signature State

DHMH 17 Rev 1/2001

Registrar

2008▶

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JULY **Physician** 2008<sup>Year</sup> 15 G. 3:10 P CORRTE HAINES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON 8. Date of Birth (Month, Day, Yes If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days OHIO Director Ĩ/939 68 293-32-9676 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show 10d. Inside City Limits notified at 1 XYes 2 □ No Director MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be 13103 BRIDGE VIEW COURT 20772 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐XNo BLACK Specific þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) the s 1 and 2 should be filed wif Health and Mental Hygier Item 27 is marked other th 5+ EDUCATOR GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GLADYS LANDERS JACK HAINES 20772 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13103 BRIDGE VIEW COURT UPPER MARLBORO, MARYLAND ROBERTA HAINES/WIFE Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages -1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/22/2008 HARMONY CEMETERY LANDOVER, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME May 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** evebral VESCULER disease or condition resulting in death) Hecident 15min /Medical Due to (or as a consequence of): Examiner Due to (oras a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed Hypertensin burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the 38 IF FEMALE nse i 23c. if yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign be c Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2 10 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital; 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation Injury death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death the f 6 ☐ Could not be 3 ☐ Suicide in by t Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Höspital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Mo

7401152 Furbes

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print) M. Camilland

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 27, 2008 **Physician** 5:15 Рм Halton Joseph Francis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 3706 37th Place Cottage City Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year 7-28-1943 7. Age (In yrs. last birthday, **Funeral** Days 64 Yrs Altoona, PA -34-2942 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if w Medical Examinar must be notified at once. 1 Yes 2 □ No Cottage City MD Prince George's Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20722 United States 3706 37th Place 12. Was Decedent Ever in U.S.
Armed Forces?
1 20 No 1960
If Yes, Give
Year or Dates: 1960 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No 1960-1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No ð 3 Widowed 4 Divorced 1962 Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Case Design Remodeling Home Repair Specialist 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph E Halton Catherine Young 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3706 37th Place Cottage City, MD 20722 Violet Halton ( wife ) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Fort Lincoln Crematory 7-29-08 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Social Licensee Brentwood, MD 20722 3401 Bladensburg Road My 4 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Year disease or condition resulting in death) Metastatic Cancer Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☐ No 24a. Was an autopsy perform 2 **A**No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Cartifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 24 29d. Date signed (Month, Day, Year) 7/28/2008 29b. Signature and title of certifier 29c. License number 15185

State Registrar

32. Registrar's Signature

31. Date filed (Month, Day, Year, 2008

John E. McKnight, MD



address of person who completed cause of death (Item 23a) (Type, Print)

1160 Varnum St NE

Washington, DC 20017 Suite 108

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:14 a M 26 2008 Erika Marie Horner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min 96 Berlin, Germany Director 577-01-4008 1/18/1912 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d Inside City Limits show ns 23a or 28a-f shorn Director 1 XYes 2 □ No Riverdale MD Prince George's death with the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 5907 Cleveland Avenue 20737 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or iten traumatic event, the Medical Examinar 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I **other than** " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be rith and Mental F. ပ Martha Seiter (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once. 5907 Cleveland Ave., Riverdale, MD 20737 Charlene Hoffman, Daughter 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery: 7/30/2008 | Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue ens Hyattsville, MD 2078 Gasch's Funeral Home, P.A. 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATRIAL PIBRILL ASION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β HYPERTENSION 1 ☐ Yes 2 ☐ MO 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Completed DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 □Yes 2 □ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

にがん Baltimore, Maryland 21215-0036

filled in by To the I within 2 State

29b. Signature and title of certifier

29c. License number MD

D0058290

29d. Date signed (Month, Day, Year) 26/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUTTATH, SYII SARVIS AUENUE, SULTE 200, RIVERDALE, MY 20137 Surisiakumar

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month; Day, Year)

29a, Certifier

(Check only one)

Medical

JUL 2 9 2008



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7:17 p M July 2008 Harris 24 Gertie L. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🖺 F 82 Director 579-24-7935 August 13, 1925 Virginia Usual Residence of Decedent within 72 hours after death with the Marylanc 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar maist by nutfilled at 1 □Yes 2 K No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 125 Randolph Road 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 🗷 No Specify Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the May Injury or other traumatic event, the May Injury or other traumatic event, the May Injury or other traumatic event, the May Injury or other traumatic event, the May Injury or other traumatic event, the May Injury or other traumatic event, the May Injury or other traumatic event, the May Injury or other traumatic event, the May Injury or other traumatic event, the May Injury or other traumatic event the May Injury or other traumati 5+ School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å Unknown Unknown Rather 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Randolph Road, Silver Spring, Maryland 20904 Raymond S. Harris - Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln Crematory 07/30/2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Hone, Inc. 10 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the diseast shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, jst only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aortic Dissection disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cauce pulsuage or injury Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-trans Cause Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 No detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ Hypotension 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 □Yes 2 X No 1 ☐ Yes 2 🗆 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 1 Marient 2 Impatient 3 Impat Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

JUL 9 2008

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MID

18

D0064100

July 25, 2008

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

July 26,

Day

2008

4c. County of Death

Year

Montgomery

Race - American Indian, Black, White, etc.

Own Home

White

Specify:

Month

3. Time of Death

8:14 pM

(State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

vears

1 ☐ Yes 2 No

#2C

be executed physician and the burial-transi Box 68760 use as the P.O. signed b Records, cate has page 2 s certificate Division of Vital Hospital or Attending Physician: After this death. Director: hours after To the Hospital within 24 hours a To the Funeral C

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Completed

Be

Certification: To

Medical

23d. Date of delivery 1 Live birth 2 Fetal dea Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Alzheimer's Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 在 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cless d25410 July 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registra 31. Date filed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

Helen Virginia Holt

4a. Facility Name (If not institution, give street and number)

15300 Pine Orchard Drive,

**Physician** 

Examiner

the Maryland

Baltimore, Maryland 21215-0036

/Medical

Oliver Lawless, MD



0

08-05688 Lillian R. Howard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2008 25913

		l- ⊢or State Registrar					Cerunc	ale Oi	Deau			- 10		Reg. No.		3. Time of Death	
Physicia I Exami	an/	1. Decedent's Na	•	ddle,Last)							Date of De Month July 24, 2	Day	Year	2228 hrs			
		4a. Facility Name 2404 Shad	(if not institution	on, give s	street and nu	ımber)		4	4b. City, Town, or Location of Death Suitland					4c. County of Death Prince George's			
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)													an North		
Director		244-02-2019 1 M 2 X F 52 Yrs. Months Days Hours Min.								JAn	25, 19	956 C	<sup>ountry</sup> Carolina				
ž.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits					
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be filed within 12 nouts arter beath will the Madyanov Hygiene. Red other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Director	10e. Street and N	Number						10f. Zip C	ode					of What Co	untry?	
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, or it	Fur	3 Widowed			1 Yes f Yes, Give Ye	2 X	No	1 Yes 2 X No specify: Specify: Black							ck		
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d Men is mar tic eve	10	19a. Informant's	9a. Informant's Name/Relationship (Type, Print )  Antonio Edwards/Son  19b. Mailing Address (Street and Number of Street and Number of Pisnosition (Name of Disposition (Name of														
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Department of Important:		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1/2 rs all							shall'	s Fun	eral H	Iome					
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The law requires that the death certificate be executed cate has been signed by the attending physician and maps? Should be detached for use as the burial - transit	7		DED	-	AMENDE	D TIS	7-29-08,	TNG N									
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he atte	Physicia	1 Yes 2 No 9 ✓ Unknown Pregnant at time of death 5 Other (Specify)							100 5			to the course of death?					
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the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certif			ide		T- 45-	back of my	knowledge,	death oc	curred at the	e time, o	tate and p	olace, and	due to the	cause(s) an	d manner as	stated.	
vithin 2	completely	(Check only one) 2 29b. Signature	<b>✓</b> Medical	Examine	r:On the ba	sis of exan	nination and/	or investi	gation, in my	y opinio	n, death o	occurred a	at the time,	date and pla	ice, and due	to the cause(s)	
To To	8	29b. Signature	and title of ce	rtifier	// 15		-		29		se numbe	er				(Month, Day, Year)	
		Mish	n Kha	siel	/ M					O.C	.M.E. 			July	/ 25, 2008 		
		30. Name and	address of pe Brassell, N				eath (Item 23 Examine		Penn St	treet,	Baltimo	re, MD	21201				
	Sto			2254	132	- M	r's Signature		P ME	7							
Reg	Sta istr		JUL	9 2	008	Bleen	-	G	ASSEL )								

DHMH 17 Rev 1/2001 OCME 2006

25914

			For State of Maryland / Department of Health a  - State of Maryland / Department of Health a  - Certificate of Death			a. No.						
	Physici		1. Decedent's Name (First, Middle, Last) Albert Richard Hance		Date of Death uly 22	2008 Year	3. Time of Death 0016 M					
	/Medio Examin		4a. Facifity Name (If not institution, give street and number)  Harford Memorial Hospital  4b. City, Town, or Location of Havre De Grad			4c. County of De Harford						
	Funeral Director		5. Social Security Number 216–18–5449 6. Sex 1 3 4 2 F 83 1 7 6 83 1 8 7 7 8 8 8 1 8 8 1 8 8 8 8 8 8 8 8 8	Min.	Date of Birth (Month, Day, Yug 21 1	<sup>'ear)</sup> 9. B 924 Ma	irthplace (State or Foreign Country) ryland					
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Calvert Huntingtown				10d. Inside City Limits					
	h with the 23a or 28a	Funeral Director	10e. Street and Number 1210 Plum Point Road 10f. Zip Code 20639			g. Citizen of What ( nited Sta						
9036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, Ina Medical Examinant national and once.	þ	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 See 2 No If Yes, Specify Cuban, Mexicar Yes, Give 43-45		y Yes or No- can, etc.)	Black, Wh	Race - American Indian, Black, White, etc. white					
1215-0036	within 72 h ane. Ihan "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary Gecondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	st of working		6b. Kind of Busines retail sa	·					
()    and 21	id be filed vental Hygie ked other ic	To Be Co		er's Name (F Sisso	First, Middle, Ma N							
	alth and M	-	19a. Informant's Name/Relationship (Type, Print) David K. Hance – son  19b. Mailing Address (Street and Number 1210 Plum Pt. Rd. F.	er or Rural A Huntin	oute Number (gtown, M	D 20639	Zip Code)					
	Pages 1 enent of Henunt: If Item		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	24 20 ery	08 <sup>20</sup> Po:	oc. Location - City or rt Republ	r Town, State ic Maryland					
Balt	permit. Departrimports any nji		21. Signalur of Funer II Service Licensee  22. Name and Address of Facility 405 Broomes Is.				20676					
•	Pnysician /Medical Examiner	iner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	mediate Cause (Final isease or condition soulting in death)  Septic Shack  Due to (or as a consequence of):  UR. May TRACT IAPECTAN								
,x 68760,	The law requires that the death certificate be executed to has been signed by the attending physicien and bege 2 should be detached for use as the buriat-transit	/Medical Examiner	Due to (or as a consequence of):  d									
.0. Box	that the death cert ed by the attendin detached for use :	Physician/N	ysician/I	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		23d. Date of d Month	Day Year					
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	l.	23e. Did toba		to the cause of death?  Probably 4 □Unknown					
al Record		Completed			24a. Was an autopsy performe	id? death?						
Vits (	sician: Th	Be	Hospital: A.C.		Check only one)							
ion of	ding After fune	ation: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA Other: 4 Nu  27. Manner of Death 1 Denatural 5 Pending 2 Accident investigation  1 Denatural 5 Pending (Month, Day Year) 28b. Time of Injury 4 Work? 1 Yes 2 Injury at Work? 1 Yes 2 Injury at Work?	280		ce 6 Other (Sp injury occurred	ecify)					
Divisi	el or Attendi s efter death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f	Location (Stree City or Town,	et and Number or I State)	Rural Route Number,					
	To the Hospitel or A within 24 hours efter To the Funeral Directompletely filled in by	edicai	29a. Certifier (Check only one)  (Check one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check one)	nd place, and ath occurred	due to the cau at the time, date	se(s) and manner as and place, and de	as stated. ue to the cause(s)					
	With To	Σ	29b. Signature and title of certifier  29c. License number	201		I. Date signed (Mor						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	276	***	7-22-2	DOS					
de	N2+1		Jason M. Birnbaum, M.D., 602 S. Atwood Rd., Ste. 2	206. B	el Air.	MD 2101	4					
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrates Signature									

Certificate of Death

	Di	recto
timore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland tment of Health and Mental Hygiene.	tant: if Item 27 Is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at

**Examiner** the burial-trar attending physician for use as the burial pe signed by the a this

Division or Vital Records, P.O. Box 68760.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** FLORENCE B. HIGGS 2008 12:12A<sup>M</sup> JULY 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Asbury-Solomons Health Care Center Solomons Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 🔽 F 578-24-0621 102 11-30-1905 MA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Calvert 1 ☐ Yes 2 X No Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11450 Asbury Circle, Apt. #428 20688 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 2 Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Artist Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank L. Besson Elise Lobera 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia H. Downey (Daughter) 5633 Dartmouth Street, Churchton, Maryland 20733 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 7/31/08 Alexandria, Virginia 21. Signature of Funeral Service Licensee Departity Imports any Injuries Rausch Funeral Home, P.A. 22. Name and Address of Facility St 5 P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Abdomina disease or condition resulting in death) /Medical Due to (or as a consequence of) Advancel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Value DISELSE 1 ☐ Yes 2MNo 3 Probably 4 Unknown Completed ENSIGN 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 0057242 July 30, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. John Barth, III, MD 14090 Solomons Island Rd., Suite 2500, Solomons, MD 20688 30. Name and address of person who completed cause of de dkn 10 31. Date filed (Month, Day, Year) 32. Registraris Signature State Registrar 3 0 2008

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** TURNER E. 11:45P HANNA /Medical JIILY 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CLINTON NURSING & REHABILITATION CTR. PRINCE GEORGE'S CLINTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□ F Months Days Hours Director 83 250-20-7299 March 28,1925 LakeCity, Usual Residence of Deceden 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at D.C. Washington 1 ☑ Yes 2 ☐ No Director death with the 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES Funeral 20019-4917 827 BURNS STREET S.E. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Backhoe Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental Victoria Britton Hanna ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelda Hanna /Daughter 827 Burns Street S.E. Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 ☐ Donaţion 5 ☐ Other (Specify) July 30,2008 Maryland National Laurel, Maryland of Funeral Service License ander S. ) Mariboro Pope.P.A. Pikė/Forėstville, Md. 20747 23a. Part 1. Enter the Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □No 2 XNo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗵 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) d manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35206 July 29, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William T. Tanner, M.D. 11701 Livingston Rd. ft. Washington, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Sign State JUL 3 0 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death
Month 27 **JOHNSON** NANCY JANE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S COMMUNITY HOSPITAL DOCTORS LANHAM If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🕏 F Months Yrs. 79 241-32-0764 8/1/1928 Williamston, NC Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3707 Donnell Drive 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 2X No 3 ☑ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry grade completed (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Processor Federal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Franklin Ruffin Katie Sue Roberson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula A. Moore / Daughter 15160 Pawleys Place Waldorf, Maryland 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/1/2008 Clinton, Maryland Resurrection Cem. 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service License 0101085 5538 Marlboro Pike Forestville, Maryland 20747 23a. Pirt1 - into the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardio respirator disease or condition resulting in death) Due to (or as a consequence of): eritoni if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of): SSIGLE schemic resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? renal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HIS tory OF esophageal 01

**Physician** /Medical Examiner

Department of Heal Important: If item 2 any injury or other

Pages 1

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

**Funeral** 

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Extrained at

12 should be filed with and Mental Hygier 7 Is marked other th

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

law requires that the death certificate be executed

Examiner Physician/Medical 2

attending physician and for use as the burial-transit signed I Completed page certificate director, Be this Certification: To After th funeral death. 24 hours after death.

• Funeral Director: A pletely filled in by the fu

Medical completely within 2

or Attending

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical

22100

examiner'

1 ☐ Yes

27. Manner of Leath

1 Natural 2 Accident

3 Suicide

29a. Certifie

4 Homicide

(Check only one)

1 □ Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

1 ☐ Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 ☐ Pending investigation

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 ☐ Other (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 Could not be

determined

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. BOX 297 Nima H. Calafino. Greenheit

31. Date filed (Month, Day, Year)

JUL 3 Q 2008

32. Registrar's Signa

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ollie Johnson 2008 July 23. 5:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert County Nursing Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 214-28-9172 78 MD July 11, 1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edival Examiner must be notified at MD 1 ☐Yes 2 X No Director Calvert Prince Frederick Pages 1 and 2 should be filed within 72 hours after death with the Inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1965 Joe Harris Road 20678 USA Funeral 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No 1 ☐ Yes 2 🖾 No Specify. þ Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Homebuilder Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Johnson Sidonia Parker 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorisa Johnson - Daughter 1965 Joe Harris Road, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important; if it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Cheltenham Veterans Cem. 8/1/2008 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gladys Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Bladder 17) nary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Iner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Physician/Medical ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atheroscierotte Cordinvasculas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Demenho 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Advance 24a. Was an autopsy performed? Ancemia 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Certification: To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: A d in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Saltimore, Maryland 21215-0036

Box 68760.

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or Vital Records,

Division

State Registrar 29b. Signature and title of certifier

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Deale

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

c. Surana.

29c. License number

D 50653

29d. Date signed (Month, Day, Year)

SURANA

7-24-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JMMY 18, Day 2008 Edna E. Jackson 10:55 P M 4b. City, Town, or Location of Death Hyattsville 4c. County of Death Prince George's 4a. Facility Name (If not institution, give street and number) Heartland Nursing Home 8. Date of Birth (Month, Day, Year) April 24, 1924 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Months 1 M 25KF 84 577-36-1418 Mississippi Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits 1 XIXes 2 □ No Hyattsville Maryland Prince George's 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? 6900 Riggs Road 20783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forcess? 1 | Yes 2 | No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed 17. Father's Name (First, Middle, Last)
Lemuel Staves 18. Mother's Name (First, Middle, Maiden Surname)
Beatrice Fleming 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4201 Butterworth Pl. NW #438 Washington, D.C. 20016 Ernestine Keaton (Sister) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Metropolitan Crematory 7/28/08 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4217 9th Street, N.W. Washington, D.C. mall 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1∐Yes X2XINo 1☐ Yes 2XNC 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident

**Physician** /Medical Examiner be executed burial-transit and

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once.

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

or Attending

To the Hospital

within 24 hours after death.

To the Funeral Director: A

filled in by

Medical

Examine physician the as attending nse ed by the a signed t been sig has page 2 s certificate l director, After this funeral Certification:

Physician/Medical þ Completed Be ို

IF FEMALE: 23b. Was decedent pregnant

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20770 Victor Onyejiaka, m.d. 7325A Hanover Pkwy Greenbelt, MD 31. Date filed (Month, Day, Year)

State Registrar

29 JUL 2008

6 Could not be determined



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			1- State of Maryland / Department of Health and Mental Hygiene, per me, g890,04/17/09ahb Certificate of Death  State of Maryland / Department of Health and Mental Hygiene, 25920
	Physicia	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year
	/Medic	al	TADE OLLIE JONES  4b. City, Town, or Location of Death  4c. County of Death
	Examin	er	HARBOR HOSPITAL BALTIMORE NIN
1	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 Months Days Hours Min.  7. Age (In yrs. last birthday)  Yrs.  1 Nonths Days Hours Min.  7. Age (In yrs. last birthday)  Yrs.  7. Age (In yrs. last birthday)  Yrs.  8. Date of Birth (Month, Day, Year)  7. Age (In yrs. last birthday)
	/land low at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside by Limits
	should be filed within 72 hours after death with the Maryland nnd Mental Hygiene. Ind Mental Hygiene. In marked other than "natural" or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Director	Md. N/X Baltimore 1 Yes 2 No
	3a or 2		10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?
1	tems 2	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
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Baltimore, Maryland 21215-0036	l 2 should be filed v h and Mental Hygie r is marked other t raumatic event, th	Be	17. Father's Name (First, Middle Last)  18. Mother's Name (First, Middle, Maiden Surpame)  18. Mother's Name (First, Middle, Maiden Surpame)  18. Mother's Name (First, Middle, Maiden Surpame)
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Ž,	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		Jessica Contz (Mother) 38/4 St Marcauts Balt Md. 21725  20a. Method of Disposition (Name of ), Date , 20c. Location, City or Town, State
mor	0 0		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  200. Method of Disposition (Value of Disposition) (Value of Dispo
altii	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service U.e. see 22. Name and Address 41 cility 3111 M1. 22
LLI	\$0 E 8 8		23a. Part1. Enter the\disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart flyilure. List only one cause on each line.  Approximate Interval Between Onest and Death
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	/Medical Examiner		Due to (or as a consequence of):
	\$M.	Jer	DUBLINGING TEMPLOONS
_	Attending Physician: The law requires that the death cartificate be executed reach.  reach: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  CERTIFICATION APPROVED BY MEDICAL EXAMINER  Due to (or as a consequence of):
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ho 以( ) P.O. Box	death c attend d for us	ician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)  23d. Date of delivery Month Day Year
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T. Wr.	Attend death. sctor; y the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined by the determined control of the de
江首	ital or restater rai Dire	Certi	4 Hornicide building, etc. (Specify) City of Town, State)
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th Within To th	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	X		30. Name and address of fer on who completed cause of death (Item 23a) (Type, Print)
K	, A 4		30. Name and address of From who completed cause of death (Item 23a) (Type, Print)  273 Penins-12 From RD Srite F Ains/N MD21012
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			For State Registrar	State of N	/larylan	d / Depa	rtment of F	lealth a	and M	ental Hy	giene	2008	25921
			Decedent's Name (First, Middle, L.)							2. Date of De		D. — — — —	3. Time of Death
	Physicia /Medic	_	Ralph E. Kelbaug							Month	Da	Year 2008	2:57 AM
	Examin	er	4a. Facility Name (If not institution, gi		/		4b. City, Town, or Location of Death Scalisbur 当					County of Death	
	Funeral			Sex 7.7	Age (In yrs. I	ast birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir	th.	Q Righ	place (State or Foreign
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	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	a-f sh	ctor	MD Worce	ster	Ве	rlin							1 ☐ Yes 2 🕱 No
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What Cou	intry?
	eath v	ra l	2 Harwich Court	12. Was Deceder	at Ever in II.	S 13 V	2181		igin? /Sne	city Ves or No		USA 14. Race - Amer	ican Indian
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force:  1 V Yes 2 [  If Yes, Give  Year or Dates	s? ] No		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☒ No			Rican, etc.)	,-	Black, White	, etc.
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	To the Hospital or Attending Physic within 24 hours after death.  To the Funeral Director: After this ce completely filled in by the funeral directors.	Medical C	29a. Certifier Certifying I (Check only one) CI Medical Ex	Physician: To the be aminer: On the basis and manner	of examina	wledge, deatl tion and/or in	n occurred at the ti vestigation, in my	me, date ar opinion, dea	nd place, a ath occurre	and due to the	cause(s	s) and manner as nd place, and due	stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25922 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $p^{M}$ Mary Elizabeth Kincaid 7/24/2008 3:55 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 😡 F Months Days Hours Min. 72 577-48-7532 3/11/1936 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1KTYes 2 □ No College Park Prince George's 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3512 Duke Street 20740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Personnel Officer U.S. Department of State 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin B. Kincaid Gwendolyn Alsop 19a. Informant's Name/Relationship (Type. Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Kincaid, Brother 9231 Limestone Pl., College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lincoln Cemetery: 7/30/2008 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small Bowel Obstruction disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Metastatic Lung Cancer Due to (or as a consequence of) If any leading to himedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 1 ☐ Yes 2 ☐ No 2 🔀 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

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**Physician** 

/Medical

Examiner

**Funeral** 

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Respiratory Failure 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🙀 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M.D. D0064100 July 25, 2008

31. Date filed (Month, Day, Year) JUL 2 9 2008

Smitha Bhikkaji

1500 Forest Glen Rd., Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygien 2008 25923 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 25, 7:35 P M Alice K. Kalikow July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Home Columbia Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Director 124-12-0727 91 New York 1916 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other than "natural", or Itama 23a or 28a-f ahow vant, the Medical Examinar must be notified at 1 X Yes 2 No MDHoward Ellicott City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4044 Firefly Way 21042 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Systems Analyst NIH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) Samuel Kadish Anna Moses 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traum Jeanne K. Longford - Daughter 4044 Firefly Way Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t. Pages 1 rtment of h 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment Important: If any injury of 4 ☐ Donation 5 ☐ Other (Specify) 7/27/2008 Judean Mem. Gardens Olney, Maryland 21. Signature, of Fuperal Service Licensee Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? hes 2□ No 1 ☐ Yes 1 Yes Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other 2 No 2 1 Tes 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Cedar come 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelsecca Jon MD 31. Date filed (Month, Day, Year)

JUL 29 **B**gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** 25, 12:46 P M Williamma Kingamayuki Ju1y /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Months Hours 341-22-9686 25, Director 82 1925 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location fshow 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wadish Examiner must be notified at MD Montgomery Silver Spring 1X Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with lealth and Mental Hygiene. Bel Pre Health & Rehab Center 2601 Bel Pre Road 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: unknown Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. **Black** 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 12 Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. King, Sr. Elizabeth Chears 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Anthony G. King- Nephew 9441 Georgian Way Owings Mill, Maryland 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of the Important: If ite any injury or ot July 29, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Beltsville, Maryland 22. Name and Address of Facility McGuire Funeral Service, 7400 Georgia Ave., NW Wash., D.C. 20012 21. Signature of Funeral Service License znou 23a. Part 1. Enter the disease, or complifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition resulting in death) Physician 280 /Medical Examiner couling wheel Sequentially list conditions, if any, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed omyok sician and burial-trans to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s 24a Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2' No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After thi completely filled in by the funeral To the within 2

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month/Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Drive, Olney, MD 20832 Vladimir Rakhmanin, MD

Registrar

31. Date filed (Month, Day, Year) 29 JUL 2008

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 24. Thelma Fanaroff Kinland 2008 9:12 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Summerville Assisted Living Potomac Montgomery 8. Date of Birth (Month, Day, Year)
Oct. 11, 1 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1918 Washington, DC 1 □ M 2 🗓 F 89 Director 577-24-0629 Usual Residence of Decedent 72 hours after death with the Maryland show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Wedical Examiner must be notified Director 1X Yes 2 □ No MD Frederick Jefferson 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 21755 4121 Springview Drive U.S.A. Funeral or Items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Mas Decedent Eve Armed Forces? 1 ☐Yes 2 ☑ No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: ģ Specify: White 3K Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) oe filed wh. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Federal Government I and 2 should be filed w fealth and Mental Hygier om 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Nathan Fanaroff Sarah Elman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Healt Important: If Item 27 any injury or other to Leonard Kinland - Son 4121 Springview Drive Jefferson, MD 21755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lebanon Cemetery 7/27/08 Adelphi, Maryland 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Paritoneal Abcess Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans Metastatic Colon Cancer tnat initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical attending p IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 📉 No Month Year Day 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Alzheimer's 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Hospital or Attending Physiclan: The certificate performed? 1 ☐Yes 2 No : After this certifics e funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 4 hours after death. Funeral Director: A tely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 70 D57884 2572008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Damien J. Doyle, MD 1801 East Jefferson Street Rockville, MD 20852 31. Date filed (Month, Day, Year) 2. Registrar's Signature JUL Registrar

Division or Vital Records, P.O. Box 68760,

State Registrar DHMH 17 Rev 1/2001

within 2

DIL

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHAWAN



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and manner stated.

histon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M



29c. License number

North old Mill Bottom Rd, Annapolis

29d. Date signed (Month. Dav. Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear 0329 M **Physician** 2008 Eastland M. Lewis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dorchest Cambrid General 1020H If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min 1 □ M 2 🗸 F Months Days Hours 93 217-28-3209 5/15/1915 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I're. Madical Expirative Talling at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 ☑ No Director Maryland Dorchester Wingate 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21675 Dorchester 2015 Wingate Bishops Head Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify. ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Todd ပ John Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Reginald D. Lewis / Son 3347 Golden Hill Rd., Church Creek, MD 21622 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8/7/2008 4 Donation 5 Dother (Specify) Dorchester Memorial Park Cambridge, MD Rure of Funeral Service Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home, 308 High St., Cambridge, MD 21613 23a Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dai disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 XNo Month Day Pregnant at time of death 4 Pregnant 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) ambridge MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

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Б	car	ni	ne	ī

Lexington Park 45920 West Sunrise Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2 □ F 578-58-7666 60 Yrs Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location event, the Mictical Examiner must be notified at Directo Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 5 45920 West Sunrise Drive 20653 Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or þ 1 □Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any flujury or other traumatic event, Its once. Photo Journalist 12 17. Father's Name (First, Middle, Last) ge 3 Heinz Pau1 Leibe ဂ္ 19a. Informant's Name/Relationship (Type. Print) 21452 Esquire Court Susan Virginia Cook Liebe /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Ju1y 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21 Signature of Funeral Service Picerbee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** esophagial hemorrhage
Due to (or as a consequence of): /Medical **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-1 Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by after 24a. Was an certificate Division of Vital 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No d in by the f 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier D452597 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Jeffery Brown, M.D. 26840 Pt. Lookout Road Leonardtown, MD 20650 P.O. Box 664 31. Date filed (Month, Day, Year) 32: Registrar's Signature State JUL 2 8 2003 Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Paul Curtis Leibe Ju1y 23. 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death St. Marv's Birthplace (State or Foreign Country) District of Columbia August 4, 1947 10d. Inside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Newspaper 18. Mother's Name (First, Middle, Maiden Surname) Margaret Theresa Warfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lexington Park, MD 20653 20c. Location - City or Town, State Alexandria, Virginia Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 P.A. Approximate Interval Between Onset and Death whene 23d. Date of delivery Day Year Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 2 PNo 1 ☐Yes 2 ☐No Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 7-24-08

Physician	
/Medical	
Examiner	

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar

	1 - State Registrar Certificate of Death Reg. No. 2008												
	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		V- av	3. Time of Death				
ian cal	Raul Rom	ulo Ller	ena			JULY	Da 29	3 2006	3 331 M. M				
ner	4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death		4c.	. County of Deatl	h				
	Washington County	Hospital		Hagers	town			Washingt	on				
	5. Social Security Number 6. Sex	7. Age (In yrs. li M 2□ F 70		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 06/11/	th y, Year)	9. Birti Co	hplace (State or Foreign untry) ador				
	Usual Residence of Decedent												
tor	10a. State 10b. County Washingto:		gersto						10d. Inside City Limits 1    Yes 2 □ No				
Funeral Director	10e. Street and Number 11042 Sani Lane			10f. Zip Code 21742			10g. Citizen of What Country?  Ecuador						
era		2. Was Decedent Ever in U.S	S 13 W		ispanic Origin? (Sr	pecify Yes or No							
by Fun	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ∐Yes 2 <b>∑</b> No If Yes, Give Year or Dates:		/as Decedent of H Yes, specify Cuba XYes 2 ☐ No	Black, White	ck, White, etc. y: White							
Completed by	15. Decedent's Educa (Specify only highest grade	completed)	16a. Decede (Give k life. D	Industry									
E O	Elementary/Secondary (0-12)	College (1-4or 5+)		echanic	,			Self Emp	loyed				
Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maider	Surname)					
To B	Segundo M. Lleren	a			Dolore	es Arrio	ola						
Γ	19a. Informant's Name/Relationship (Type Michel Llerena	e. Print) (Daughter)			and Number or Ru n P1. De				Zip Code)				
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. P	emetery, crem	ition (Name of atory or other place emetery	re)	Date	Contract 1 Francisco						
	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses			Name and Addres	08-10	0-08	Gua	yaquii,	Ecuador				
	Wanda C.	Bacon Ca	34/ 32	H Bac 447 14th	on Funer Street,	al Home N. W.	. In Wash	ıç. ington,	D.C. 20010				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between												
	Immediate Cause (Final disease or condition	Mitzel  Due to (or as a consequence Cocagal		Onset and Death									
	resulting in death)	Due to (or as a consequ	Caraia	2 0									
L	Sequentially list conditions, b.			Negati	PHIOCO	"(_C_ U	3 days						
ie	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						9				
Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					-					
			,										
Medical	d.												
	IF FEMALE: 23	Bc. If yes, outcome of pregna	ncy					23d. Date of de	livery				
Completed by Physician/	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3	Ectopic pregnanc Other (specify)	у			Month	Day Year				
ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		- Carlor (opcony) _									
y P	Part II. Other significant conditions cont	ributing to death but not resu	alting in the un	derlying cause giv	en in Part I.	23e. Did 1	Did tobacco use contribute to the cause of death?						
p	Stroke					1 🗆	Yes 2 No 3 Probably 4 Unknown						
lete	End Stage	Reval De	seas	e		24a. Was	an	24b. Were au	Vere autopsy findings available				
I E	0	prior to completion of cause of death?											
Ф	25. Was case referred to medical				26. Place of Dea	1 □ Yes	2 N	o 1 □Yes	2 10				
m	examiner?	ospital:	ER/Outpatient	3 DOA Oth	or:								
Ë	27. Manner of Death	28a. Date of Injury	28b. Time of				ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred						
atio	1₅ Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury										
Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
Medical		er: On the basis of examina and manner stated.											
ž	29b. Signature and title of certifier	taul		29c. Licens			29d. D	ate signed (Mont	h, Day, Year)				
	29b. Signature and title of certifier  H. CLY	3000		D5	3853		7	/28/	08				
	30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, F	Print)	C- '	100		2 1	MA 0 217/-				
1	HABIB CHOTA			TIETAM	ST, F	14628	510	own;	MD 21740				
ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture										

08-05591 Antoine McCray

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 25930 Certificate of Death Reg. No. Registrar Ameno#10e PenFam P008 3. Time of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Physician/ Month Day July 21, 2008 2029 hrs ' Examiner Me Antoine McCray 1c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Goerge's Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number oreign Washington **Funeral** Months Days Hours Director 09/23/1974 33 Yrs 1X M 2 219-80-1118 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Ę 10a State Y Yes 2 No Gambrills Anne Arundel - Odenton 23a or 28a-f show notified at once. MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland that of Health and Mental Hygiene.
nnt: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 2463 Cheyenne Drive 21054-1695 -21113 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. must be Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: Black Yes 2 X No specify: f Yes, Give Year Divorced Widowed 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Trucking Business Self Employed 5-0036 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kathleen Green Larry McCray Be MD 2121 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2 808 Cypress Point Circle; Mitchellville, MD 20721 Larry McCray - Father 20c. Location - City or Town, State If item 2 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/30/2008 Clinton, Maryland Resurrection Cremetery Donation 5 Other Specify 22. Name and Address of Facility 21. Sign, ture of Funeral Service Licenses Freeman Funeral Services 14594 Peech Road: Temple Hills from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Maryland arrest, shock, or h Approximate Interval . Enter the disease, or Between Onset and hysician e. List only one cause on e Death **ledical** a Multiple Gunshot Wounds Immediate Cause (Final disease .xaminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED UNPENDED attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If ves. outcome of pregnancy IF FEMALE: Month Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atte be detached for t 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö Unknown Yes 2 ✔ No 3 Probably 4 þ ۵ Completed 24b. Were autopsy findings available of Vital Records, 24a Was an s been s prior to completion of cause of autopsy performed? death? has page 2 s 1 V Yes ✓ Yes 2 1No 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be examiner? Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 V ER/Outpatient 3 this ဥ 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death After Subject shot Certification: FOUND: Yes 2 V No Natural Division Pending 24 hours after death. Director: d in by the f 2056 hrs Jul 21, 2008 2 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 60th Veterans Monument Drive, Fairmount Heights, MD Could not be 3 Suicide determined (Specify) Other (grass) 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 22, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner 32. Registrar's Signa 31. Date filed (Month, Day, Year) **State** 2000

DHMH 17 Rev 1/2001 OCME 2006

Registrar

			for State Registrar		State of Ma	aryland /		artment of I <i>rtificate of</i>				giene Reg. No.		8	259	131	
	Physicia	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month							Day Year			eath P <sub>M</sub>					
	/Medic	al .	Billy Ray McQueen							Ju1y	26						
J	Examin	er						4b. City, Town,		n of Death					2.5		
						if Under 1 Year	If Under 24 Hrs. 8. Date of B			th	ince G	irthplace	(State or Fo	oreign			
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and	* **		Usual Residence of 10a. State	10b. County		10c. City, Tow	n or Lo	ocation						10d. la	nside City L	imits	
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h the	r 28a notif	Director	10e. Street and Nu		orges	Deres	VII.	10f. Zip Code				10g. Citiz	zen of What (	Country?			
ith wit	f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11250 E	vans Trail	L #202			2070	5				USA				
er des		Funeral	11. Marital Status		12. Was Decedent E Armed Forces?		13.1	Was Decedent of If Yes, specify Cul	Hispanic ( ban, Mexic	Origin? (Special) can, Puerto	ecify Yes or No Rican, etc.)	)•	<ol> <li>Race - An Black, Wi</li> </ol>		dian,		
U Z I Z I J-0030 filed within 72 hours after death with the Maryland	l", or xamir	by F	1 ☐ Never Mar 3 ☐ Widowed	ried 2⊠ Mamied 4 □ Divorced	1 X Yes 2 ☐ N If Yes, Give Year or Dates:	971–73		1 □ Yes 2 🗷 No	Specif	fy:			Specify:	Lack			
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d be fi	and marked other than aumatic event, <u>the</u> M	) Be		,							,		Surname)				
2 should be	mark	ဥ	Zeart Wa	lame/Relationship (7	Type. Print)	19	b. Mailir	ng Address (Stree			iae McQt		en ; City or Town, State, Zip Code)				
and 2	27 Is er trau		Bernice	McQueen /	Spouse	1	1250	O Evans 1	[rail	#202	Belts	ville	MD	2070	5		
Pages 1 and 2	of He fitem r oth		20a. Method of Dis	sposition  Comparison 3	Removal from State			osition (Name of matory or other pla			Date		cation - City	or Town, S	State		
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	ysician		23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										en				
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certif	D 66	n/Me	IF FEMALE:	nt pregnant	23c. If yes, outcome					- 1-110			23d. Date of delivery				
death	e atte	230. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  1 Ves 2 No.  4 Pregnant at time of death 5 Other (specify)								Day Year							
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The law requires that the death cert	n signed by the attendir ald be detached for use	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to Cirrhosis of Liver  1 Yes 2 No 3 Pi														
aw rec	s been si	olete	Hepatiti	is C Disea							24a. Was an 24b. W			ere autopsy findings available			
Cirrhosis of Liver  Hepatitis C Disease  Type II Diabetes Mellitus; Hypertension  1   Yes   2   No    1   Yes   2   No    24a. Was an autopsy performed?    1   Yes   2   No    24b. Was an autopsy performed?    1   Yes   2   No    1   Yes   1   No								death'	prior to completion of cause of death? I □ Yes 2 □ No								
clan:	ertifica ector,	Be C	25. Was case refe examiner?							ce of Death	h (Check only						
Physi	After this certificate ha funeral director, page	은	1 X Yes 2 No  Hospital: 1 I Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 6 Other (Specific Residence 1) Nursing Home 5 Residence 1) Nursing Home 5 Residence 1 Nursing Home 5 Residence 1) Nursing Home 5 Residence 1 Nursing Home 5 Residence 1) Nursing Home 5 Residence 1 Nursing Home 5 Residence 1 Nursing Home 5 Residence 1) Nursing Home 5 Residence 1 Nursing Home 5 Resi								ecify)						
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e Hospit	e Funera letely fille	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as structured at the time, date and place, and due to and manner stated.														
To th	29b. Signature and title of certifier 29c. License number 29c.								29d. Dat	e signed (Mo	nth, Day,	Year)					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 259 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 27, 2008 **Physician** 10:51 A M Maria Mardones Ines /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Marlboro Prince George's 9538 Castle Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 12/25/1970 Hours Min. 1 □ M 2 X X 37 Chile 228-28-2796 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 TXX Director Maryland Prince George's Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Chile 20772 9538 Castle Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married XX Yes 2□ No Chilean Specify: Spanish Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elena Mardones Rosa Jose Mardones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 9538 Castle Drive Upper Marlboro, Maryland Carlos Macal / Husband Juan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State August 3,2008 | Edgewater, Maryland 4 □ Donation 5 □ Other (Specify) Kalas Crematory 21. Signatur Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 1. Kely 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Paux Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Tastric Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or, injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 TYes 2 TNo 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 2 No this certificate 1□ Yes 25. Was case referred to medical funeral director, 26. Place of Death Check onl one Be examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

death certificate be executed P.O. Box 68760. Division or Vital Records, To the Hospital or within 24 hours after death.

To the Funeral Lifrector; Aft

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

and manner stated.

29c. License number

Elkridge

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Dav. Year)

B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6095 Marshaler Drive

31. Date filed (Month, Day, Year) 2008

29a. Certifier (Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician**  $A^{M}$ 1:30 JULY 24 2008 MORTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY Examiner SILVER SPRING HOLY CROSS HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 □ XF 577-64-0506 61 WASHINGTON, DC JULY 7 Director 1947 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1X Yes 2 □ No LANDOVER HILLS PRINCE GEORGE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20784 3612 WARNER AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No BLACK Specify: Specify: 3 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Meule once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT SUPERVISOR 1\_YR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY WINTERS HARRISON R. MASON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782 19a. Informant's Name/Relationship (Type. Print) STREET # 102 HYATTSVILLE, MARYLAND 2613 NICOLSON WILLIAM T. MORTON JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State CHELTENHAM, MARYLAND MD VETERAN'S CEMETERY 8/5/08 4 Donation 5 Dother (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO PULMONARY ARREST /Medical Due to (or as a consequence of) Examiner HYPERCARBIC RESPIRATORY FAILURE Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Dav 5 Other (specify) ned by the a detached f 9 Unknown 9 D Unknown signed be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown OBSTRUCTIVE SLEEP APNEA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page certificate 1 ☐Yes 2X No 1 ☐ Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 📈 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death After 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 1 🕅 Natural 5 Pending investigation n 24 hours after death.

Pe Funeral Director: A pletely filled in by the fu М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. the To the within ? 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0061937 Candley L. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. WILSON, MD - 1500 FOREST GLENRD, SILVER SPRING, MD 2901 CANDACE 32. Registrar's Sig atu 31. Date filed (Month, Day, Year) State JUL-2 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.20 25934 1 - State AMEND#5, 18&20b, perFH, 8/6/08, DPS, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 26,2008 9:07am Irene Rothschild Menter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brighton Gardens Assited Living Chevy Chase If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Dec 12,1918 9. Birthplace (State or Foreign Original Sequence Strategy Marinters 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 F Davs Hours New York Director 105-03-5868 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Chevy Chase MD Montgomery 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 United States 5555 Friendship Blvd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married <u>ک</u> 1 ☐ Yes 2 █No Specify. Specify: White 3- Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Engle Jacob Rothschild Lillian Engel ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Menter/Son 3800 Ridgelea Dr., Fairfax, VA 22031 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arlington Nat Cem Arlington, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signat A Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4<sup>Onset and Death</sup> Immediate Cause (Final Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of): Kidney Failure 3 Mos Sequentially list conditions, and good for the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan Was autopsy performed? 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Living 5 ☐ Pending investigation 1 🙀 Natural 1 □Yes 2 □No 2 ☐ Accident 6 ☐Could not be 3 ☐ Suicide

The law requires that the death certificate be executed

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

3altimore, Maryland 21215-0036

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Department Important: If any Injury or once.

**Physician** 

/Medical

Examiner

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After

death.

P.O. Box 68760. Division of Vital Records, spital or Attendii tours after death. neral Director; A

within 24 hours a

To the Funeral I

completely filled To the Hospital

Registrar

State

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier f Internist

and manner stated.

oldg 2, WRAMC

determined

4 ☐ Homicide

29a. Certifier

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 19<sup>pay</sup> / 2008 **Physician** 2:00 pM Rahila Minayar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Gaithersburg Shady Grove Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 01/09/1919 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min. 1 □ M 2√2 F 89 Afghanistan 215-13-0051 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 🔀 No Director Gaithersburg MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 Afghanistan 52 Anna Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Never Married 2 ☐ Married Specify: Persian Baltimore, Maryland 21215-0036 1 ∐Yes 2√∑No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "na College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bebe Hawa Ali Minayar ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Printsister-20877 permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trau once. Gaithersburg, MD 52 Anna Court Alia Hashim Minayar/in law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington 07/24/08 Adelphi, MD 22. Name and Address of Facility Universal Mortuary Inc. 21. Signature of Funeral Service License 411 Kennedy St. NW Washington, DC 20011 Kim rath 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atherosclerotic cordiovascular disease Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 🗷 No 9 Unknown certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day, Year) 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death, re Funeral Director: A sletely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 2. State Registrar

Medical Center Drive, - 9901 Mistry Alicia 32. Registrar's Sign 31. Date filed (Month, Day, Year) 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Justrym

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

29c. License number

D59738

Rocky. He

29d. Date signed (Month, Day, Year)

July 29, 2008

Md. 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2008 Elmer Ju<sub>1</sub>y 25 1:18 Albert Moreland, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Center Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 X M 2 □ F Director 220-32-5661 73 02-26-1935 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1150 Marlboro Road USA 20711 Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) timber salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ E1mer Moreland Mildred Frances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Virginia F. Moreland, wife 1150 Marlboro Road, Lothian, 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of himportant: if ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens 07-31-2008 Dunkirk, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on conclusions. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner physician and the burial-transit Due to (or as a consequence of P.O. Box 68760, for use as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) as been signed by the a 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 2 No 3 Probably certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform page 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) \$ No Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by t filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

DRW 10

State Registrar

SAM 31. Date filed (Month, Day, Year) 2 2008▶ JUL 9

29b. Signature and title of certifier

32. Registras Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 5-22 per F.H. g883 9/C3/MRcats Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** lode WALLACE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 ☐ M 2 ☐ F 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 25 m. Country) n/a Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28a-f ehow eny injury or other traumatic event, the Medical Exemples. 10b. County 10d Inside City Limits 10a. State 10c. City, Town or Location Anne Arundel Brooklyn1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 207 W. Riverview Road 21225 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 Ho Specify: ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Infant Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Todd Wallace Miller Teresa Henard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Henard (mother) 207 W. Riverview Rd. Brooklyn, Maryland 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 8/3/08 Glen Burnie, MD. 4 ☐ Donation 5 ☐ Other (Specify) Elizabeth A. Groff, Manager 22. Name and Address of Facility Gary L. Kaufman Funeral Home 21. Signature of Funeral Service Licenses MMP, Inc. 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only opercause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Frematurity /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-translt The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. P P 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ٩ 2 ER/Outpatient 3 DOA ihis 28a. Date of Injury (Month, Day Year) 27. Manner of Deal 28b. Time of 28d. Describe how injury occurred Certification; To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Natural 2 Accident 5 Pending investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36143 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUTUITIE 028 MYPNA ORTEGA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 0 0 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle, Last) Physician 0630 Laure /Medical 4b. City, Town, or Location of Death 4a-Fechlity Neme (If not institution, give street and number, 4c. County of Deeth Examiner Cheverly HOSPITAI (teorac's xeome's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social/Security Number-7. Age (In yrs. last birthday) 6. Sex **Funeral** Mand 1 M 2 □ F Yrs None Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryle Department of Heelth end Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or itema 23e or 28e-1 show eny injury or other traumatic event, the Medical Examiner must be notified at Huattsville 1 Yes 2 No Prince George's **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number Kenilworth 20781 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Race - American Indian 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 ۵ H15Danic 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant mant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) UD 5108 Kenilworth the AD15 wallsville Elva Mar 20b. Place of Disposition (Name of cometery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/1/08 Cheverly 4 Donation 5 Dother (Specify) Krince George's Hospital 22. Name and Address of Facility 21. Signature of Funeral Service License George's Hospital Center Cheverly UD 3001 HOSDITAL Drive Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear to litre. List only one course on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760. ina Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Medical Certification: To Be Completed 24a. Wes en autopsy performed? 1 ☐ Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day 28b. Time of Injury 28c. Injury et Work? 5 Pending investigation 1 | Yes 2 | No 2 Accident vithin 24 hours efter dee
To the Funeral Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steled.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier

State

29b. Signature and title of certifier

. Fomula

Year)

2

r's Signeture

2191

29c. License number

29d. Date signed (Month, Dey, Year)

08-05820 Wanda Oliver

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 29, 2008 2110 hrs **Medical Examiner** Wanda Michelle Oliver 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St Marv's St. Mary's Hospital Leonardtown 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country Tyland November 21, Min Months Days Hours Director 220-84-6183 2 X F 33 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 X No 28a-f shov St. Mary's Mechanicsville Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20659 27025 Thompson Corner Road USA with the 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No ò If Yes. Give Year Yes 2 x No specify: Specify. White hours after Divorced "natural", ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I injury or other traumatic event, the Medical F Stock Clerk Retail Store 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wanda Jacqueline Shotwell Dennis Edwin Oliver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) P Mechanicsville, MD 20659 26472 Loveville Road Wanda Jacqueline Lathroum / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition fimore, crematory or other place) August 6. 1 X Burial 2 Cremation 3 Removal from Stat Chaptico, Maryland Christ Episcopal Cemetery 2008 Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Survice Linens Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 206 Leonardtown, MD 20650 Approximate Interval tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complica Physician Between Onset and failure. List only one cause on each line Medical Death a. Probable asphyxia associated with schizophrenia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed AMENDED 23a,27,28a-f, perME, g882 8/13/08 TT Physician/Medical X UNPENDED attending physician for use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify, Yes 2 No 9 ✔ Unknown g Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one the Hospital or Attending Physician: hin 24 hours after death 25. Was case referred to medica Division of Vital Be Other<sub>4</sub> examiner? Hospital: 1 / Inpatient Residence 6 Other ER/Outpatient 3 DOA Nursing Home 5 this ဥ 1 Y Yes 2 No 28d. Describe how injury occurred subject placed 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After 27. Manner of Death Certification: foreign object in her mouth 1 Natural Yes 2X No Pending To the Funeral Director: completely fil ed in by the Fnd 7/29/08 Fnd 2015 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) C-Unit 25500 Point 3 Could not be Suicide (Specify) Lookout Rd, Leonardtown, MD St. Mary's Hospital Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E July 30, 2008 le 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D.

Registrar Univin 17 Rev 1/2001

**OCME 2006** 

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25940 State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>2008  $J_{\mathbf{u}}^{\text{Monin}}$  26, **Physician** Retha Lee 01ds A  $^{\mathsf{M}}$ 4:45 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Southern Maryland Hospital Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0ct. | 22, 1935 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** North Carolina 579-52-3396 1 M 2 → F 72 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Maryland Prince George's Temple Hills 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3410 23rd Parkway 20748 USA 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ♣ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking filed withi Hygiene. Commercial Bank Teller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be file and Mental H Be William Streeter, Sr. Essie Hopkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun William Streeter, Jr. - Brother 3410 23rd Parkway, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Homestead Cemetery 8/2/2008 4 □ Donation 5 □ Other (Specify) Greenville, NC 21. Signature f Fun 1 Service Licensee George Por Karas Funeral Home, P.A. letes 6160 Oxon Hill Rd., Oxon Hill, Md 20745 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 Man 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate has all director, page 2 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital within 24 hours a t Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature

31. Date filed (Month, Day, Year

2008

ame and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

D 18545 JULY 26, 2008 HNE COUTER WALDEF, W. 2002

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25941 Certificate of Death Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 28 12:33 PM July Phyllis Marie 01savsky 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Lothian 159 Konrad Morgan Way Date of Birth (Month, Day, Year) 01–12–1926 9. Birthplace (State or Foreign Country) Wash., D.C. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 1 ☐ M 2 1 F 82 578-26-4904

Lothian

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Pear1

20711

(Give kind of work done during most of working life. DO NOT use retired)

administrative assistant

10f. Zip Code

1 ☐ Yes 2 ☑ No

16a. Decedent's Usual Occupation

10d. Inside City Limits

10g. Citizen of What Country?

14. Race - American Indian

White

Black, White, etc.

USA

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

G.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16b. Kind of Business/Industry

elevator

McKay

1 ☐ Yes 2 ☐ No

10c. City, Town or Location

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Usual Residence of Decedent

10e. Street and Number

11. Marital Status

10b. County

159 Konrad Morgan Way

1 Never Married 2 Married

3 ₩ Widowed 4 Divorced

Elementary/Secondary (0-12)

Chester

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Anne Arundel

15. Decedent's Education (Specify only highest grade completed)

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

Green

10a. State

Directo

Funeral

2

Be Completed

ပ

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran by the a þ signed b within 24 hours after death.

To the Funeral Director: After of completely filled in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Joseph C. McKay,	Jr., cousin 21	<u>513 Point Loc</u>	kout Road,	Callaway, M	D 20620
20a. Method of Disposition	20b. Place of D	Disposition (Name of crematory or other place)	Date	20c. Location - Ci	ty or Town, State
1 M Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	gton National	08-01-20	08 Suitland	l, MD
21. Signature of Funeral Service License	е	22. Name and Address of	Facility Rausch	n Funeral Ho	me, P.A.
William R. (	ston	8325 Mt. Har	mony Lane,	Owings, MD	20736
23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	ations that caused the death. Do not e cause on each line.				Approximate Interval Between Onset and Death
disease or condition resulting in death)	n ly union	Sulmin	871		
	Due to (or as a consequence of	chalestern	)		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of	· · +	+		
Cause (Disease or injury that initiated events	House	Kegway	llyn		
resulting in death) Last	Due to (or as a consequence of	110			
		9 7			
IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 21€ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date Monti	,
Part II. Other significant conditions con	tributing to death but not resulting in t	he underlying cause given in	n Part I. 23e	e. Did tobacco use contrib	ute to the cause of death?
Malnuri	trende			1 ☐ Yes 2 HNo 3	☐ Probably 4 ☐ Unknown
Menna	reined benien		248	a. Was an 24b. We	ere autopsy findings available
oster	South		10	performed? de	or to completion of cause of ath? ☑Yes 2 ☐ No
25. Was case referred to medical examiner?		26	6. Place of Death (Check	( only one)	
1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outp	oatient 3 DOA Other:	4 ☐ Nursing Home 5	Residence 6 □Other	(Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Ti	me of 28c. Injury at ury Work?	28d. De:	scribe how injury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Loc City	ation (Street and Number or Town, State)	or Rural Route Number,
	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.				
29b. Signature and title of certifier	21 .	29c. License nu	umber	29d. Date signed	(Month, Day, Year)
> Alum K	Edgerunde mi	) D23	826	7/30	108
30. Name and address of person who co	mpleted cause of death (Item 23a) (T	ype, Print)	A Da Da	11 11	estac and a
Glenn K Edger	sm De M) 771	na ra polo oc	11 446, 1321	11 CIMI	11/ 11/ 70/30
31. Date filed (Month, Day, Year)	32. Registra Signature		-	/	1

DHMH 17 Rev 1/2001

State

Registrar

JUL

dew

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** July 28, 2008 Peterson 12:25 A Suzanne Waldrop /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Morningside House Waldorf Charles If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Aug. 27, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2XX 215-46-2999 85 North Carolina Director 1922 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2xxNo Director Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12807 Pine Tree Lane 20744 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status should be filed within 72 hours after on Mental Hygiene. marked other than "natural", or itel 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otis. Stanley Waldrop Susie Dalv 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miller H. Peterson / Husband 12807 Pine Tree Lane Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Kalas Crematory 4 □ Donation 5 □ Other (Specify) 7/29/2008 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespicatory arrespiratory arrespira Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed and physician ar s the burial-ti Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as the attending IF FEMALE: be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1□ Yes XXINO 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 No 은 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After XX Natural Injury 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 EXEcrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month. Dev. Year)

DHMH 17 Rev 1/200

31. Date filed (Month, Day, State

address of person

2008

DHMH 17 Rev 1/2001

Registrar

29

2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25944 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 2008 **Physician** 24, 3:20 P M John L. Pusecker /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Nov. 29, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1⊠M 2□F Ohio Nov. 80 Director 284-24-4840 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, In a Medical Exyminer must be notified at 1 X Yes 2 □ No Director Gaithersburg MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20877 #912 415 Russell Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🙀 No Specify. Specify: White 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Air Elementary/Secondary (0-12) Heating and Conditioning Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel McVicker ည Neil Pusecker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Silver Spring, MD 20901 8610 Geren Rd. Deborah A. Linn - Step Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 【 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/26/08 Falls Church, Virginia National Crematory 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
Edward Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service License Donald ( -1091 Rockville Pike asttemens 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Kena disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burlal-transit Due to (or as a consequence of): attending physician for use as the burlal P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been s page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 🖾 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 ☐ Yes W No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) he Hospital or Attending Pl n 24 hours after death. he Funeral Director: After the pletely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

State Registrar

29 DHMH 17 Rev 1/2001

nd

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

150n Registrar's Signature

32

208

## Laurie Palmer 08-05611

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physici		1- For State Registrar 1. Decedent's Name (First, Midd	dle, Last)	Certificate	of Health and Ment of Death	2. Date of Death		3. Time of Death
l Exami	iner	Laure  4a. Facility Name (if not instituting the state of		almer	4b. City, Town, or Location of	July 22, 20	Day Year 008 4c. County of Deat	1730 hrs
		Route 4 at Plum Poir		5 5	Huntingtown		Calvert	
uneral irector		5. Social Security Number 046-48-1550	6. Sex 7. Agr	e (In yrs. last birthday 56	If Under 1 Year If Under  Months Days Hours  Yrs.	24Hrs. 8. Date of Birt 01–27-	C	rthplace (State or Foreigr ountry) onnecticut
any		Usual Residence of Decedent  10a. State  10b. County	,	10c. City, Town or Lo	cation		<del> </del>	10d. Inside City Limits
28a-f show	or		mbiana		Lisbon			1 X Yes 2 No
2 should be first writin 12 nous area usen with me was yantu hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shu matic event, the Medical Examiner must be notified at once	Director	10e. Street and Number			10f. Zip Code	10	Og. Citizen of What Cou	untry?
23a o notifi		516 West Wash	nington Stree		44432 Was Decedent of Hispanic Origi	n? ( Specify Yes or No-	USA 114. Race - Ame	rican Indian, Black,
ritems	Funeral	1 Never Married 2	Married Armed Forces?		If Yes, specify Cuban, Mexican,		White, etc.	,,
all, or	by F		ivorced If Yes, Give Year or Dates:	1	Yes 2 X No specify:			ite
"natur Exam		<ol> <li>Decedent's Education (Sp Elementary/Secondary (0-12</li> </ol>		durin	dent's Usual Occupation (Give k g most of working life. DO NOT เ		16b. Kind of Business	/Industry
than edical	Completed	Elementary/Secondary (0-12	4		egistered nurse		health o	are
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pennu, rages i and 2 situation be lifed whili Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med	Be c	Monroe Hale  19a. Informant's Name/Relation		10h Mo	Bar	bara		chimpf
and N 27 is n	To	Jeremy D. East		- 14	Pennsylvania			
Health item		20a. Method of Disposition		20b. Place of Dis	position (Name of cemetery, rother place)	Date	20c. Location - City of	r Town, State
Department of Healt Department of Healt Important: If item injury or other tra		1 X Burial 2 Crematic		ale	ew Cemetery	07-29-08	East Live	rpool, OH
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/sician		23a. Part I. Enter the disease, of	K. Gran	the death. Do not ent	8325 Mt. Harmo			20736 Approximate Interval
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e uean ceruncate be ex the attending physician ed for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 V U	nknown g Unknown	t time of death 2	Other (Specify)	pregnancy	23d. Date of delive Month	Day Year
the rooping or Artening Frystram: The law requires that the usean contribute be executed in 24 hours after death.  The Poneral Director: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial - transit.	Completed by P			h but not resulting in t	ne underlying cause given in Pa	1 Yes  24a. Was autop perfor 1 Yes	psy prior to rmed? death?	obably 4 Unknown utopsy findings available completion of cause of
nis cert	Be (	25. Was case referred to medic examiner?	Hospital:	ent 2 ER/Outpat	Othor		Residence 6 🗸 Oth	er: Scene
eath. or: After th the funeral	tion: To		28a. Date of Injunding Jul 22, 2008	28b. Time (ear) 1726 hrs		Bicyclist str	how injury occurred uck by motor vehi	cle
s after de	Certification:	3 Suicide 6 Co	uld not be	njury - At home, farm, s ajor Road / Highv	street, factory, office building, etc /ay		Street and Number or F State) um Point Road, Hun	Rural Route Number, City tingtown, MD
ours a		29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	aminer: On the basis of exa	ny knowledge, death o imination and/or inves	ccurred at the time, date and pla igation, in my opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
in 24 hour the Funer: pletely fill			and manner stated.		29c. License number	·	29d. Date signed (M	
vithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	29b. Signature and title of certif	fier (					
within 24 hour To the Funers completely fill	Medi	29b. Signature and title of certif	Hallar		O.C.M.E.		July 23, 2008	
within 24 hour To the Funers completely fill	Medi	30. Name and address of person	Adela		O.C.M.E.	21201	July 23, 2008	

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29d. Date signed (Month, Day, Year)

July 25, 2008

			For State Registrar			otate of	riviar	yıanı				Death		ental Hy	Reg. N	/ 11	08		948
	Physic	ian	Decedent's Nam		,									<ol><li>Date of D Month</li></ol>	D	ay	Year	3. Time	
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- 700			5. Social Security I				7 Age /	n vrs 1	ast birthday,		on H		24 Hrs.	8. Date of Bi		Princ		orge":	
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	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	_	10a. State	10b. County			10	Dc. City	, Town or L	ocation								10d. Inside (	
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	or 28	Dire	10e. Street and Nu								ip Code				10g. C	itizen of	What Cou	ntry?	
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36	or if	Y F		ried 2 X Marrie	ed	1 ☐ Yes If Yes, Giv	2≱∏ No re			1 🗆 Yes	2[ <b>X</b> No	Specify:		,		Specif	v:	Afr	ican
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٥٢ ا	ding Ph h. After th funeral		27. Manner of Dea		1	28a. Date o	of Injury h, Day Y	ear)	28b. Time o	of	28c. Inju			8d. Describe				<i></i>	
<u>Ö</u>	Attending r death. sctor: After sy the funer	atic	1 XNatural 2 ☐ Accident	5 Pending investiga	ition	1,11,0/11	,, 1		,, y	М		Yes 2□	No						
Division	F 0 F C	Certification	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin		28e. Place buildir	of injury ng, etc. (	- At hor Specify	me, farm, st	reet, facto	ory, office	•	2	8f. Location City or To	(Street a own, Sta	and Numt te)	ber or Run	al Route Nu	mber,
	pita ours eral filled		29a. Certifier	1 Certifying	Physici	an: To the	best of n	ny knov	vledge, deal	h occurre	d at the	time, date ar	nd place, a	nd due to the	cause	s) and m	anner as s	stated.	
	Hos 24 hc Fun etely	dical	(Check only one)	2 Medical E	xaminer	: On the ba	asis of ex	aminat	ion and/or ir	vestigati	on, in my	opinion, dea	ath occurre	ed at the time	, date a	nd place,	and due	to the cause	(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John L. Marshall, M.D. 3800 Reservoir Road, NW Washington, DC 20007 31. Date filed (Month, Day, Year) JUL 2 8 2008

29b. Signature and title of certifie

State

Registrar

29c. License number

DC19655

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death July 25, Year 2008 **Physician** 3:10 AM Charles Rabb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Nov. 28, 9. Birthplace (State or Foreign Rhode Island 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1⊠M 2□ F 75 Director 105-28-4206 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercitor most by motified at 1 X Yes 2 □ No Director MD Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 53 Calabash Court U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 XYes 2 No Army
If Yes, Give
Year or Dates: Korean 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Journalist Journalism 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental h Louis Rabinowitz Rose Moscowitz ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traunonce. 53 Calabash Court Rockville, MD 20852 Louisa R. Corrado - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/28/2008 Olney, Maryland Judean Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc 1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licenses Donald 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEMIC ARDIDMMOPATHY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): aftending pl IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year 5 Other (specify) o the funeral director, page 2 should be detached 1 □ Yes 2 □ No The law requires that the 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 15 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 212 No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one, Be Other: A Nursing Home 5 Residence 6 Other (Specify) 211No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0018084 Z.C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTROSE RD. ESH ()(N) 7 EL, M-DRegistrar's Signature 0121

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

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Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person

JUL 2 8 2008

31. Date filed (Month, Day

300GACLANTFOXLN#222 Bowie

of death (Item 23a) (Type, Print)

32. Registrar's Sigr

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lichael Javier Stennett	State of Maryland / Department of Health and Mental Hygiene

lease Type or Print in Black Indelible ink. Ensure All Cop	les Are Legible.			
State of Maryland / Department of Health and Mental Certificate of Death	Hygiene Reg. No.	2008	25949	additions.
ime (First, Middle Last)	2 Date of Death	3 Tim	ne of Death	

		1- For State Registrar		Cei	rtificate o	f Dea	ath			Reg	, No.	20	UC	5231
Physicia		1. Decedent's Name (First, Midd	le,Last)							ate of Death	Day	Year		Time of Death
ledical Exami	ner	MICHAEL JAVIE	R STENNET	T					Ju	ily 26, 20	08			2215 hrs
		4a. Facility Name (if not institution 2514 Markham Lane	n, give street and n	umber)			, Town, or Lo dover	ocation of De	eath		- 1	ounty of De		
Ermanni		Social Security Number	6. Sex	7. Age (In yrs. I	act hirthday/		ider 1 Year	If Under 24	iŭes lo	Data of Right				ace (State or
Funeral Director				10.5		Mon			Min,			i Ear	raindal e	achinetan
		220-06-9121 Usual Residence of Decedent	1 <sup>X</sup> M 2 F	36	Yrs	i. <u> </u>				6/5/19	972		Countr	D.C.
any		10a. State 10b. County		10c. City,	, Town or Locat	ion	-						10	d. Inside City Limits
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Maryland 28a-f show d at once	cto	Maryland Prince  10e. Street and Number	George's	Gle	nn Dale		ip Code	-		100	a. Citizer	n of What C		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medicul Examilier must be notified at once	Director	12119 Guinever	e Place				20769						,	
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death r item rust b	Funeral	1 X Never Married 2 M	arried Armed F	orces?	If Y	es, spe	cify Cuban, I	Mexican, Pue	erto Rica	n, etc.)		White, etc		
after (	by F	3 Widowed 4 Div	orced If Yes, Give Ye		1 <u>X</u>	Yes	2 No	specify:			Sp	pecify: His	spar	nic
hours		15. Decedent's Education (Spe	cify only highest gra	de completed)	16a. Deceder			n (Give kind OO NOT use		done		d of Busines		
11215-0036 Id be filed within 72 hours a fental Hygiene. tarked other than "natura event, the Medicul Examin	Completed	Elementary/Secondary (0-12)		1-4 or 5+)			,		retired)					
5-0036 led within 7 Hygiene. other than the Medica	mo	12 17. Father's Name (First, Middle,	2		Restau	ran						vate ]	Indı	ıstry
215- be filed ntal Hyg rked of	Be C	,	Last)					3.Mother's Na			aiden Su	rname)		
212 212 wild be Ments mark	To B	Hugh Stennett  19a. Informant's Name/Relations	hin (Type, Print )		19b Mailine	a Addre	SS (Street a	lelva i and Number	Rodn or Bural	ev Poute Numb	ner City	or Town St	tato 7iu	Codo)
MD d 2 shot lth and lt	-	Melva Honore /			1.1									,
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altimore, Imit. Pages 1 and partment of Healt portant: If item jury or other trai		1 X Burial 2 Cremation		OIII State	crematory or ot	her plac	e)							
Baltin permit. P Departme Importan injury or	**	4 Donation 5 Other Sp 21. Signature of Funeral Service		Re	surrect	ion Name ar	Cemet nd Address o	eryl 8	/2/2	<u>008 l</u>	Cli	nton.	Mary	yland
Dep Triji		Front a.	ava M	01085	55	38 1	Marlha	of Facility Po	ope . Ica E	Funera	11 H(	omes,	P. A	A.
Physician		23al Partil. Enter the disease, or	compligations that of	aused the death	. Do not enter t	he mode	e of dying, su	uch as cardia	ac or resp	oresta piratory arres	st, shock	or heart	CYIE	Approximate Interval
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xaminer		or condition resulting in death)		a consequence o									$\neg$	·
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and and			d										+	
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8760, tificate bong physic	Ž	IF FEMALE: 23b. Was decedent pregnant in the		outcome of preg	•			Ectopic pre	an on a			Date of deliv	-	V
Sox 687 leath certific e attending p	cia	past 12 months?		nant at time of de	2 Fe	her (Sp		_ccopic pre	gnancy		I MI	onth	Day	Year
Box e death c the atten	Physicia	1 Yes 2 No 9 Unit	g Unkn	own										
P.O.	by P	Part II. Other significant condit	ions contributing t	o death but not re	esulting in the u	ınderiyii	ng cause giv	en in Part I.						cause of death?
S, P.C									- L	1 Yes	2 🗸 N	10 3 P	'robably	y 4 Unknown
ord:	Completed								Ŧ	24a. Was ar autops				sy findings available pletion of cause of
ecc he lar age 2	Ē								_	perform		death 1 ✔	1?	2 No
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of Vital Records, ng Physician: The law requin ther this certificate has been is meral director, page 2 should be	TO B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3	DOA OI	ther Nu	rsing Hor	me 5 R	Residence	e 6 🗸 Ot	her: Sc	ene
n of ding Ph	آڌ	27. Manner of Death	28a. Date	of Injury , Day,Year)	28b. Time of I	njury	28c. Injury	at Work?		Describe ho		occurred		
Division of Vital F tal or Attending Physician: 15 after death. al Director: After this certifi led in by the funeral director,	Certification:	Natural 5 Pend 2 Accident Inves	ing FOUND stigation Jul 26, 2		FOUND: 2215 hrs		1 Yes	s 2 🗸 No	Sub	ject was :	SHOL			
ivis or A after Direc	<u></u>	3 Suicide 6 Coule	d not be 28e. Plac	e of Injury - At ho		et, facto	ry, office buil	lding, etc.		Location (Stor Town, Sta		Number or	Rural F	Route Number, City
Spital hours neeral	ě	4 Homiciae	mined (Specify)	Local Stree	et				2514	Markham	Lane, L	_andover,	Md	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Pt one) 2 Medical Example Certifying Pt Cert	nysician: To the bes											uso(s)
To t Com	Medical	29b. Signature and title of certifie	and manner s				9c. License r		ou at tile					
		C C Certifie		4.			O.C.M.					te signed <i>(h</i> 7, 2008	vionin,	uay, rearj
	-	30 Name and address of	1.11	o of do-th //	220)		J.J.IVI.				July Z	., 2000		
[5]	ļ	<ol> <li>Name and address of person Jack Titus MD. Dep</li> </ol>	who completed cause uty Chief Medic			n Stre	et, Baltin	nore. MD	21201					
Sta	ate	<u> </u>		egistrar's Signatu				-, ,						
Registi	rar	31. Date filed (Month, Day, Year)	Kleen	B A	and a									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Elizabeth Schlager July 26, 2008 /Medical 2:27 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10109 Clearspring Road Damascus Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Director 132-20-7632 85 Nov. 20, 1922 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show at r 28a-f sh 1 □Yes 2 No Directo Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 10109 Clearspring Road by Funeral 20872 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Heary and Constitution Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Bureau permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Secretary of Standards (NIST) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Daniel Webster Williams Elizabeth Ellen Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Geiger, daughter 10109 Clearspring Road, Damascus, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7/28/2008 Alexandria, Virginia 21. Sun ture of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cus (Final disease or con mion resulting in death) Physician 0 /Medical Due to (or as a consequence of) Examiner >/04RS obbacco Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? ßί austust DOLON 1 Yes 21 No or Attending Physician: Be 25. Was case r erred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No P 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760 P.O. I Division or Vital Records,

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

Medical

Gail T. Grffin, MD, 1502 South Main Street, Mount Airy, Maryland 21771 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

mo 55/04

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #25, perME, g882 8/27/08 Frificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 2008 Robert Loys Sminkey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 160-24-2969 Director 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Directo St. Mary's Maryland Leonardtown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21731 Lake Circle 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status SMINKEY, Robert Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Submarine Commander U.S. Navy marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hilmportant: If item 27 is marked oth any injury or other traumatic event Loys Albert Sminkey Dorothy Louise Dietrich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline M. Sminkey / Wife 21731 Lake Circle, Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory July 29, 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensed 22. Name and Address of Facility Mattingley-Gardiner Funeral Rome, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRAL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician: The law requires that the death certificate be execute and burial-tra Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No funeral director, page 2 autopsy performe certificate 2 No Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes <del>2 → 10</del> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 56076 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY'S HUSTITAL, LEONARD TOWN. 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 2 9 2008 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 26 4:50 p<sup>M</sup> 2008 07 RUTH EMMA SELBY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Hartley Hall Nursing Home Pocomoke City 8. Date of Birth (Month, Day, Year) 11/30/1930 Birthplace (State or Foreign Country)
 Maryland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F 77 Director 217-30-8992 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 X Yes 2 ☐ No Director Pocomoke City MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 21851 1006 Market Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **X**No 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: ģ 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Gibbons John Williams 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2054 Boston Road, Pocomoke City, MD 21851 Ruth Ann Pilchard (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/29/2008 Pocomoke City, MD First Baptist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Licenses 22. Name and Address of Facility Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 Cys 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (erebrovas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 □ Yes 2 □ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I ð 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has b irector, page 2 s autopsy rmed? 2 No 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Injury 5 ☐ Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

within 24 hours a

To the Funeral I

29b. Signature and title of certifier

(Check only one)

29a. Certifier

Medical

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Tope, Print)

57

BA 2 State

31. Date filed (Month, Day, Year)

3 0 2008

32. Registrar's Signature

Registrar

			1 - For State Registrar	State of Marylar	•	artment rtificate					2008	25953
			Decedent's Name (First, Middle, La	st)					2. Date of De	ath		3. Time of Death
	Physici /Medio		Hattie R. Swe						July		, 2008	
	Examir	er	4a. Facility Name (If not institution, give 8307 Bellefonte				wn, or Locat nton	tion of Death			County of Dear	h George's
	Funeral		5. Social Security Number 6. S		. last birthday)	If Under 1	Year If Ur	nder 24 Hrs.	8. Date of Bir (Month, Da			hplace (State or Foreign untry)
	Director		577-66-6574	□м 2]ДГ F	60 Yrs.	Months [	Days Hou	urs Min.	3/9/1	948	Co	D C
	and ww		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Maryl F sho	ţo	MD Prince	George's	Clinto	n						1 <b>X</b> Yes 2 □ No
	th the or 28a	)irec	10e. Street and Number	acor gc 3	0111100	10f. Zip C	ode		[	10g. Citi	zen of What Co	untry?
	ath wi	<b>Funeral Director</b>	8307 Bellefonte				0735				USA	
	items items	-nne	11. Marital Status 1 ☐ Never Married 2 🖔 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🕅 No	J.S. 13. \	Nas Deceder f Yes, specify	nt of Hispani Cuban, Me	ic Origin? (Sp xican, Puerto	ecify Yes or No Rican, etc.)	)-	<ol> <li>Race - Ame Black, White</li> </ol>	
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Exanton rust be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	,	l∐Yes 2∭	(INo <i>Sp</i> e	ecify:			Specify: B1	ack
5-0	72 ho 'natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Deced	dent's Usual (	Occupation done during	most of work	ing	16b. Kii	nd of Business/	Industry
2121	filed within Hygiene. wher than "	Juno	Elementary/Secondary (0-12)	College (1-4or 5+)		n Res				Dar	king l	· o.t
	filed within Hygiene.  other than ent, the Menter	Be Co	17. Father's Name (First, Middle, Last,		<u> </u>	.11 1/63	- 1		e (First, Middle			300
/lar	should be f and Mental I s marked of umatic eve	To B	Sollie Turner				M	ary B	lount			
Maryland	2 sho h and is ma rauma		19a. Informant's Name/Relationship (			_					r Town, State,	
	1 and 2 Health em 27 other tr		Kimberly Smith		Place of Dispo cemetery, cren				, CIIN		, MD 2 cation - City or	
ē	Pages nent of I int: If Ite		1  Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	i Herriovai from State	ce <i>metery, ci</i> en 2 S U <b>r r e</b>			7/28	/08	C.1 -	inton,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantor intel by purified at once.		21. Signature of Funeral Service Licer		22	. Name and	Address of F	acility St	rickla	n d	Funera	1 Services
_	97. E 29		Con Trug	Starel						·	prings	,MD 20748
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the dea one cause omeach line.	th. Do not ent	er the mode o	of dying, suc	h as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
j	Physician /Medical		disease or condition resulting in death)	a	June of the contract of the co	india	4/ }	nfar	tion			
	Examiner		Convention that are distant	, Henrite	NCLON			V				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):	4.						
_	execut and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):	tins	leave	1				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physiclan and bage 2 should be detached for use as the burial-transit	dical E	(	d.								
89	ntifica ng ph	Medi	IF FEMALE:									
Вох	eath certific attending p	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3 □	Ectopic pre				2	23d. Date of de	ivery Day Year
0	the de y the a	Physician/Me	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5L	Other (spec	cify)					24,
о, С	res that the de signed by the be detached	by Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the ur	nderlying cau	se given in P	Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
ord	w require been sig should b								1 🗆 '	Yes 2	No 3□Pi	obably 4 🗍 Unknown
of Vital Records,	law r has be e 2 sh	Completed							24a. Was	psy	prior to	itopsy findings available completion of cause of
a F	an: The I tificate hator, page								perfo 1 □ Yes	2 XNo	death? 1 ☐ Ye s	2 🗆 No
ξ	10 Se Se	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outpation	+ 3 T DOA	Othor		h (Check only o		S □ Other (Spe	-26.3
ρ	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		Injury at Work?		28d. Describe			cuy)
Sion	Attending r death. ector: After by the funer	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1	,,	М	1 ☐ Yes	2 □No				
5	l or Attena after death Director: I in by the	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		eet, factory, o	ffice		28f. Location (; City or To			ural Route Number,
_	o the Hospital or At ithin 24 hours after of the Funeral Direct ompletely filled in by		29a. Certifier 1 Certifying Ph	ysician: To the best of my kniner: On the basis of examin	owledge, death	occurred at	the time, da	ite and place,	and due to the	cause(s)	and manner a	s stated.
	To the H within 24 To the Fi	Medical	one)	and manner stated.	ation and/or in				red at the time,			
	2 10		29b. Signature and title of certifier	1. IMO		1	License numl				e signed (Mont	
	0		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type. I	Print)	702	10	, .		7/24 per ma	1640
_(	SI.		IMELEX M	inanoa, MI	0 7	Sil S.	05180	RNE ?	tt 606	400	per ma	207721
	Sta Registr	_	31. Date filed (Month, 2ay, 5 ear)	22. Registrar's Sign	ature	1.					,,,,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 For State
Registrar Ameno #12 Per Fam. PGOS 6-08cm Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 Year 24, Physician 4:22 A M July Ronald Stewart /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges' Clinton Southern Maryland Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month. Day) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F 69 04/28/1939 Yrs. 374-36-5538 Michigan Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 28a-f show "natural", or Items 23a or 28a-f shov adical Examiner must be notified at 1X Yes 2 No Fort Washington MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Items 23a or? U.S.A. 20744 4004 Payne Drive by Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation Item 27 Is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Reserve Officers Asso. **Building Engineer** 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emestine Wheetley Skovil Stewart ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4004 Payne Drive; Fort Washington, MD 20744 Teresa Stewart - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important; If Ite any Injury or ot cemetery, crematory or other place)
Maryland Veteran Cemetery 08/04/2008 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland 5 Cher (Specify) 4 Donati 22. Name and Address of Facility Freeman Funeral Services of Funeral Service Licens 21. Signatul 4594 Beech Road; Temple Hills, Maryland 20748 Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nter the disease, o r heart failure. List Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-trar and attending physician Physician/Medical as the IF FEMALE nse 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 DEctopic pregnancy 1 Live birth 2 ☐ Fetal death Year Month for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy page 2 perform 2 No certificate 1 ☐ Yes 26. Place of Death (Check only one, 25. Was case referred to medical examiner? Be Other: Hospital: 1 ☐ Yes 1 patient 3□ DOA 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Records, P.O. Box 68760, **Division or Vital** To the Hospital or Attending Physician: To the Funeral Director: After the completely filled in by the funeral hours a within 24

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Morfth, Day, Year) 2008 JUL 29

(Check only one)

29b. Signature and title of certifie



of person who completed cause of death (Item 23a) (Type, Print)

ruyau

MYD

29d. Date signed (Month, Day, Year)

10403 Hospital Drive

D0052999

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra MEND#23a(b)penMD,7-30-08, BWW,MpOp Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Mary Louise Sanford 10:00 M 2008 July 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 25 F Virginia 577-26-6344 84 Dec. 25, 1923 West Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Tyes 2 TiNo Maryland Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20895 3618 Littledale Road, #304B USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Secretarial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Littleton Mary Angelina Trail 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Rose/Daughter 2305 Seminole Street, Adelphi, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug. 1, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Entir the disease, or complications that ha sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHOLANGITIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) I □Yes 2 □No 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 II No 3 Probably 4 Unknown 1 ☐ Yes 246. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

, or i

"natural",

?7 is marked other traumatic event,

item 27 i

permit. Pages 1
Department of F
Important: If ite
any Injury or ot

Director

Funeral

Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

10a. State

signed by the attending physician and is detached for use as the burial-tran icate has been ; page 2 should After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Records, P.O. Box 68760.

**Division of Vital** 

1000a.m

7/27/08

Santord, mary

Examiner

Physician/Medical Completed by

Be

State Registrar

Certification: To 27. Mann of Death 29a. Certifier Medical

1 Matural

2 Accident

3 Sulcide

4 ☐ Homicide

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OVE 31. Date filed (Month, Day, Year) 29

egistrar's Signater

15 CONSIN

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Mar 1 - State Registrar		artment of H rtificate of L			iene eg. No. 2 🛭 🗎	3 25956
	- · · ·		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic	_	Delores Ekberg	Schommer			July	27 2008	
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea	
			Renaissance Gardens - Riderwood No. 5. Social Security Number   6. Sex   7. Age	ursing Home (In yrs. last birthday)	Si If Under 1 Year	lver Spring If Under 24 Hrs.	8. Date of Birth	Prince G	
Н	Funeral Director		468-03-0895 1□ M 2점 F	95 Yrs.	Months Days	Hours Min.	(Month, Day, March 3,		thplace (State or Foreign ountry) <b>Minnesota</b>
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ecation				10d. Inside City Limits
	Mary -f sho	ţo	Maryland Prince George's		Silve	er Spring			1 □Yes 2 K No
	r 28a	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	ountry?
	th with		3160 Gracefield Road, Apt. #OG-3	121	18.	20904		U	.S.A.
98	be filed within 72 hours after death with the Maryland stal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evarinar must be notified at	y Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No If Yes, Give	)	Was Decedent of H If Yes, specify Cuba 1 □Yes 2점No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	te, etc.
5-0036	ural",	ed by	3 ■ Widowed 4 □ Divorced Year or Dates:	16a Dece	dent's Usual Occup	ation	-	16b. Kind of Business	White
15	n 72 n "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	during most of work d)		TOD. And of Business	, in load if y
2121	filed within Hygiene. rther than "	E O	Elementary/Secondary (0-12) College (1-4or 5+)	)	sonnel Repre		į	U.S. Gover	nment
b	il Hygid other ent, II	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, I	Maiden Surname)	
lar.	should be nd Mental marked o	To B	Oliver N. Ekberg				Mary McDo	nald	
Maryland	shd and sm		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number	, City or Town, State,	Zip Code)
	1 and 2 Health : em 27 l		Kevin P. Fay - Personal Rep.					ryland 20850	
altimore,	00 0 1		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, cree	osition (Name of matory or other plac coln Cemete:		Date 31/2008	20c. Location - City o  Brentwood,	
Balti	permit. Page Department Important; I any injury o		21. Signature of Funeral Service Licensee	V	2. Name and Addre	ss of Facility	Home. In	C.	
	HD = 4 G		Nancy A. Le com	he death. Do not en					Maryland 20904 Approximate
			23a. Part 1. Enter the Usease, or complications that caused t shock at he at I filter. List only one cause on each line Immediate Cause (Final	Advan		is on a lati	or respiratory air	cot,	Interval Between Onset and Death
-	Physician /Medical		disease or condition a.		cky D	KIDENTI	a		
-	Examiner		Due to (or as a	consequence of):					
		ē	Sequentially list conditions, Due to for as a	consequence of :					
	ficate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.						
0,	ificate be executed g physician and ts the burial-transit	EX	resulting in death) Last Due to (or as a	consequence of):					
68760,	ate be nysici he bu	edical	d						
		Med	IF FEMALE:						
O. Box	The law requires that the death certifi ate has been signed by the attending I age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 menths?  1 Yes 2 No 9 Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of d Month	elivery Day Year
σ.	that ned b	by Pt	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	quires an sign uld be		Chronic obstauctive	pulmo	navyd	sease	1 □ Y	es 2. 1 √No 3. 1	Probably 4 Unknown
of Vital Records,	aw requir s been s s should	Completed	End stage renal	disias	se		24a. Was a	n 24b. Were a	autopsy findings available
R	The law cate has page 2 t	m o	7				autops perfor	med?   death?	completion of cause of
ita	ilcian: The certificate ector, pag	BeC	25. Was case referred to medical			26. Place of Deat			
f V	nyslc nis ce direc	임	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatien	nt 2 ER/Outpatie	nt 3 □ DOA Oth	er: 4- Nursing Ho	ome 5 🗌 Resid	ence 6 Other (Sp	ecify)
n 0	ng Pl	ü	27. Manner of Death 28a. Date of Injury 1. ☐ Matural 5 ☐ Pending (Month, Day,		Wor		28d. Describe h	ow injury occurred	
Sio	tendi eath. or: A the fu	cati	2 Accident investigation			Yes 2□No			
Division	al or Att	Certification:	4 Homicide determined 28e. Place of Injurbuilding, etc.	y - At home, farm, sti (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of Medical Examiner: On the basis of and manner state	examination and/or in					
	To th withi To th	Ž	29b. Signature and title of certifier	1	29c. Licens			29d. Date signed (Mor	nth, Day, Year)
	10		I housen futhur	naus, M		1524		July 28	, 2008
			30. Name and address of person who completed cause of de LOVEEN J. PUTHUMANA	ath (Item 23a) (Type, 3110 ERA	Print) CEFIELD	ROAD, SI	LVERSA	RING MI	20904
	Sta Regist		31. Date filed (Month, Day, Year)  32 registral		nevile)				
			1000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland /    1 - State Registrar	Department of He Certificate of D	ealth and Mental Death	Hygiene 200 {	3 25957
	Physicia		1. Decedent's Name (First, Middle, Last) Maruh	Sesal	2. Date of Month	Day Year	3. Time of Death Z:59 PM
1	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)  Montgomery General Hoppital  5. Social Security Number  173-20-4932  6. Sex  18 M 2 F  7. Age (In yrs. last bit)  80	4b. City, Town, or L	ocation of Death  If Under 24 Hrs. 8. Date c Hours Min. (Month	4c. County of Dea	ith
	ס	ector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	rn or Location  r Spring  10f. Zip Code		10g. Citizen of What C	10d. Inside City Limits 1 ⊠Yes 2 □ No
	aa or	ä	2901 S. Leisure World Blvd. #528	20906		U.S.A.	June 1
36	s after death ", or items 2 carring run	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☑ Yes 2 □ No Army  If Yes, Give Year or Dates:  WWII	13. Was Decedent of His	panic Origin? (Specify Yes c , Mexican, Puerto Rican, etc Specify:	or No- 14. Race - Am	te, etc.
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Heath and Mental Hygiene 1 fear 21 is marked other tran "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupa (Give kind of work done du life. DO NOT use retired) tail		16b. Kind of Business	
d 2	e filed v al Hygie other t vent, th	၀၁	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Mi		
ılan	Alental rked o	To Be	Leonard Segal		Theresa Kavio	ch	
10	2 should be and Menta is marked is raumatic ev			b. Mailing Address (Street a		-	Zip Code)
a)	is 1 and 2 of Health item 27 i			444 Reach Roa of Disposition (Name of ery, crematory or other place		D 20854 20c. Location - City o	r Town, State
Baltimore,	permit. Pages Department of Important: If its any Injury or o		4 Donation 5 Other (Specify) Garder	n of Remembra	nce 7/27/08		g, Maryland
Bal	permi Depai Impol any Ir		21. Signature of Funeral Service Licensee  Schoold C. Stattlemys		i Funeral Dir I Funeral Dir Ile Pike Roc		0852
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the dath. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  2a. Due to (or as a consequence cause).	endel Inter	, such as cardiac or respirated or the such as cardiac or respirated or	ory arrest,	Approximate Interval Between Onset and Death 91) says
. Box 6	ires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknow			23d. Date of d Month	elivery Day Year
rds, P.	requires that the been signed by th hould be detache	by	Part II. Other significant conditions contributing to death but not resulting  Atro-1 Fbnll-him	in the underlying cause give		Did tobacco use contribute 1 ☐ Yes 2 ☑ No 3 ☐ I	to the cause of death?  Probably 4 Unknown
l Rec	The law ate has b	Completed			1 🗆 Y	autopsy prior to performed? death? /es 2 ☑ No 1 ☐ Ye	autopsy findings available completion of cause of
Z:	S S	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/O	Othe	26. Place of Death (Check of the charter)  7: 4 Nursing Home 5	only one) Residence 6 □Other (Sp	ecify)
n of	ding Phi h. After thi funeral	on:T	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury Injury Work?	at 28d. Desc	ribe how injury occurred	551,97
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, f building, etc. (Specify)		es 2 □No  28f. Locat City o	ion (Street and Number or F or Town, State)	Rural Route Number,
	e Hospita 24 hours e Funera eletely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death occurred at the tim and/or investigation, in my op	e, date and place, and due to inion, death occurred at the	o the cause(s) and manner time, date and place, and di	as stated. ue to the cause(s)
	-	Me	29b. Signature and title of certifier	29c. License	number	29d. Date signed (Mor	
	10		Kelmel Weller, MD	1 04	2777	July 2	4. COOS
	(		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) Richard	Weinstein, M.	2	
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 2 9 2008  32 Registrar's Signature	boute			

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State of Maryland / Department of Health and Mental Hygiene

		,	1 - For State Registrar	State of Ma	aryland	-	artment of I <i>rtificate of</i>		,	giene Reg. No. (	2008	25958
	Physici		1. Decedent's Name (First, Middle,	,					2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Elroy Reynolds  4a. Facility Name (If not institution,				4h City Town o	or Location of Deat	July		2008 ounty of Death	1:30 p <sup>™</sup>
	Examil	er	2193 Timothy Dr				Westmins		ш		arroll	
	Funeral			. Sex 7. Ag	ge (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs		h		lace (State or Foreign
	Director		578-40-7619	1 🕅 M 2 🗍 F	77	Yrs.	Months Days	Hours Min.				nsylvania
	pu ,		Usual Residence of Decedent		T							
	arylai show	-	10a. State 10b. County		10c. City, 7	Town or Lo	cation				10	0d. Inside City Limits
	8a-f	Director	Maryland Carr	:011	W	estmi	nster					1 ☐ Yes 2 🛣 No
	/ith th	Ë	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Coun	try?
	s 23s	ra	2193 Timothy D				21157				JSA	
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show folice! Expringer past be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	<sub>No</sub> Korea	n 1	Was Decedent of H fYes, specify Cub I∐Yes 2 🙀 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		I. Race - America Black, White, e Specify:	etc.
15-0036	hour tural	ed k		Year or Dates:	Confl		dent's Usual Occur	nation		10b Kind		ite
Ç	d within 72 ho giene. r than "natu	Completed	15. Decedent's (Specify only highest )			(Give	kind of work done DO NOT use retired	during most of wo.	rking	160. Kind	of Business/Ind	lustry
2	within iene. • <b>than</b>	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)		trical C			0	own Busi	ness
D	The the	Be C	17. Father's Name (First, Middle, La	st)					me (First, Middle,			
<u>a</u>	Ø # ₽ ø	To B	Elroy Sites						Emalu De	ngler	•	
Maryland	s 1 and 2 should be i f Health and Mental fem 27 is marked o other traumatic eve	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Numbe	er City or T	Town State Zin	Code)
	and 2: lealth a m 27 is ner trau		Ronald E. Sites				4 Bradsh					
<u>6</u>	s 1 at f Hea ftern othe		20a. Method of Disposition	-	20b. Plac		sition (Name of natory or other place		Date		ation - City or Tox	
gaitimore,	permit. Pages Department of Important; If It any injury or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				natory or other plac Heaven C		July 30	~		
	mit. I	1	21. Signature of Funeral Service Lig						2008	Silv	er Spri	ng, Marylan
ñ	Der Imp		2000	Dag.			Name and Addre rancis J 00 Unive					g. MD 20901
	Physician pe executed by Medical Examiner as the private priva	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Respi	iratory a consequen	rce of):  V Fai  ce of):  Coro		ery Disea	ase			Onset and Death
9		ledi										
.O. BOX	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pregnanc Other (specify)	ey		230	d. Date of delive Month I	ery Day Year
Ţ	that ned t		Part II. Other significant conditions	contributing to death b	ut not resultin	ng in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to the	e cause of death?
cords	quire, n sig ald be	d by	History of Stro	ke Hyperck	olosta	2010	mia		<b>tX</b> □Y	es 2 🗆 I	No 3☐ Proba	ably 4 ☐ Unknown
2	w rec	ete		ic, nyperen	oresce	TOTE	ii.Ta		24a. Was a	n /	24h Wore suter	osy findings available
מושו	in: The la ificate has or, page 2	e Completed	25. Was case referred to medical						autops perfor 1 □ Yes	sy med? 2 □ <b>x</b> No	prior to con death? 1 ☐ Yes	npletion of cause of
>	s cert	o Be	examiner?	Hospital:	ent 2 ☐ ER	(Outration)	Oth	or:	ath (Check only or			
5	y Phy er this	Ë	27. Manner of Death	28a. Date of Inju	iry 28	b. Time of			fome 5 Resid			)
5	th: Afte	훁ㅣ	1 <b>XX</b> Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day	y, Year)	Injury	28c. Injur Worl	kí? <sup>™</sup> Yes 2 □ No	200. 200020 ;;	on injury o	, oou i oo	
	al or Atter after dea I Director d in by the	ertification: T	3 Suicide 6 Could not determine	be Ose Bless of Init		, farm, stre			28f. Location (S City or Town	treet and N n, State)	Number or Rural	Route Number,
	e Hospita 24 hours e Funera eletely fille	Medical C	29a. Certifier (Check only one)  Check only one)  Certifying I	Physician: To the best of aminer: On the basis of and manner sta	f examination	dge, death and/or inv	occurred at the tirestigation, in my o	me, date and place opinion, death occu	e, and due to the durred at the time, o	cause(s) ar date and pl	nd manner as sta lace, and due to	ated. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier				29c. Licens	e number	2	29d. Date s	signed (Month, D	Day, Year)
	10+1		1/2	1-10				D60233		July	y 28,200	)8
	(0,,,		30. Name and address of person wh Nan Wang, MD	o completed cause of de			,	sington.	MD 20895			
	Stat	е	31. Date filed (Month, Day, Year)		ar's Signature	4 3	There					
	Registra	ır	1111 2.9 2	PAGE SALL	es Is.	A STORY	BAGAS					

			For State Registrar		State of N	naryiani		artment of <i>rtificate of</i>		Mental Hy	/gier Reg. I			
			1. Decedent's Name (First,	Middle, La	ast)					2. Date of De	eath			3. Time of Death
	Physici /Medic		Ruth M.		Spie	egelbe	rg			July 25		Day 7	Ye ar	2:15 P <sup>M</sup>
	Examin		4a. Facility Name (If not in:	stitution, giv	ve street and numbe	er)		4b. City, Town,	or Location of Death	1	4	4c. County o	f Death	
- 19 <sup>8</sup>			15908 Maple					Rockvil			1	Montgo	mery	•
	Funeral		5. Social Security Number		Sex 7.7 1 □ M 2 ဩ F	Age (In yrs. la	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days		8. Date of Bi	av Yea	ar)	9. Birthp Coun	lace (State or Foreign
	Director		087-09-7959 Usual Residence of Deced			96	Yrs.			Apr. 1	1,	1912	New	York
	land 1			County		10c. City	, Town or Lo	cation					110	0d. Inside City Limits
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	the route	Director	10e. Street and Number	ntgome	ery	, K	ockvil	10f. Zip Code			10a. (	Citizen of Wh	at Coun	trv?
	3a ol		15908 Maple	Ridae	Court			20853	ı.			.S.A.		,.
	death ms 2	Funeral	11. Marital Status	KIUG	12. Was Deceder	t Ever in U.S	i. 13. \		Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		14. Race		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evaninar must be recified at once.	ρ	1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Dir		Armed Forces 1 □Yes 2 5 If Yes, Give Year or Dates	₹ No		Yes, specify Cub		o Rican, etc.)		Black, Specify:	White, e Whit	
2-0	72 ho	Completed	15. De	cedent's E	ducation ade completed)		16a. Deced	lent's Usual Occu	pation	talan an	16b.	Kind of Busi	ness/Ind	lustry
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<u>n</u>	be fill d oth even	Be	17. Father's Name (First, M	fiddle, Last	")				18. Mother's Nam	ne (First, Middle	, Maid	en Surname)	l	
<u>Y</u>	should I and Men s marke umatic	은	Harry May						Esther 1			- 1		
lar	2 sh and is m		19a. Informant's Name/Re						and Number or Ru					Code)
o o	and tealth		Frank D. Spi		perg - Soi		l		East Ave			OK 74		
0	ges 1 If of H If iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem		Removal from Stat	e 20b. Pla	ace of Dispos metery, crem	sition (Name of natory or other pla	ce)	Date	20c.	Location - C	ity or To	wn, State
Ē	t. Pa tmer tant: jury		4 □ Donation 5 □ Ot				g Davi	d Mem. G	dns. 7/2	7/08	Fa	lls Ch	urcl	n, Virgini
Baltimore, Maryland	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Si	ervice Licer	nsee Ot	<b>*</b>	Da Da	Name and Addre	ess of Facility Goldberg ville Pike	Memoria	1 0	hape1	s, I:	nc.
			23a. Part 1. Enter the disea	ase, or com	plications that cause	ed the geath.	Do not ente	/U ROCKY	TILLE PIKE	or respiratory a	Jil]	Le, MD	<u>2</u> 08	52 Approximate
			23a. Part 1. Enter the disea shock, or heart failure Immediate Cause (Final	e. List only				, and mode of dy	ng, scor as caraico	or respiratory a	111031,			Interval Between Onset and Death
18	Physician /Medical		disease or condition resulting in death)	-	a. Cardion									
أنعر	Examiner					s a consequi	,	. 1 •	1 7.					
		-	Sequentially list conditions,			s a conseque		rdiovasc	ular Dise	ease				
	uted d ansit	ᇤ	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	~	,	,	,							
,	exec	Examiner	that initiated events resulting in death) Last		c Due to (or a	s a conseque	ence of):						+	
68760,	te be /sicia e bur	edical			. d									
9	rificate be executed ng physician and as the burial-transit	edi												
	attendin for use a	2	IF FEMALE: 23b. Was decedent pregna	int	23c. If yes, outcom	e of pregnan						23d. Date	of delive	rv
	death ce e attendii id for use	Physician/N	in the past 12 months 1 ☐ Yes 2 ☑ No		1 ☐ Live birth 4 ☐ Pregnant	at time of de		Ectopic pregnand Other (specify) _	У			Mont		Day Year
7. O	w requires that the de been signed by the should be detached	hys	9 🗆 Unknown		9 ☐ Unknown									
	requires that wen signed b nould be deta	by P	Part II. Other significant co	onditions o	contributing to death	but not resul	ting in the un	derlying cause giv	en in Part I.	23e. Did t	tobacco	o use contrib	ute to the	e cause of death?
ğ	quire en siç uld b	Pd L	Dementia							1 🗆 '	Yes	2 □ No 3	☐ Proba	ably 4⊠ Unknown
Hecords,	law re as beo 2 sho	Completed	Debility Debility							24a. Was	an	24b. We	re autop	sy findings available
	The law cate has page 2 s	E O									rmed?	pride	or to com ath?	npletion of cause of
	ician: The certificate ector, pag	ø	25. Was case referred to m	edical					26. Place of Deat		2 🔯 N	No 1 L	Yes :	2 ∐No
>	Physician: this certific ral director,	O B	examiner? —1 ∐ Yes 2 🔯 No		Hospital:	tient 2 🗆 E	R/Outpatient	3 DOA Oth				- Kil∩thor	/C===:6:	Group
	iding Physician: th. After this certifical funeral director, p	Ë	27. Manner of Death		28a. Date of In	jury 2	28b. Time of	28c. Inju	rv at	28d. Describe I			(Ѕреспу	ноте
Sion	Attending r death. sctor: Afte by the fune	ati		Pending nvestigation	(Month, D	ay, rear)	Injury	M 1 □	k? Yes 2 □No			•		
	ecto by th	<b>≅</b>		Could not be letermined	28e. Place of Ir	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (	Street	and Number	or Rural	Route Number,
5	talor safte al Din	Certification:	4 El Hosmordo		building, e	itc. (Opecity)				City or Tov	vn, Sta	ite)		
:		Medical	29a. Certifier (Check only one)  1  Ce 2  Me	rtifying Ph dical Exan	nysician: To the bes niner: On the basis and manners	of examination	ledge, death on and/or inv	occurred at the ti estigation, in my	me, date and place, opinion, death occur	, and due to the red at the time,	cause date a	(s) and manr and place, and	ner as sta d due to	ated. the cause(s)
1	vithi To th	ž	29b. Signature and title o	ertifier				29c. Licens	e number		29d. D	ate signed (	Month, D	Pay, Year)
	6		> / V	~				D355	79		,T11 1	y 25,	200	8
		-	30. Name and address of po	erson who	completed cause of	death (Item 2	23a) (Type, P				- 41	-J 2J9	2001	
			Susan J. Mil					ve. #305	Bethesd	la, MD 2	081	. 4		
	Stat		31. Date filed (Month, Day,	Year)	3 Regist	trar's Signatu	re							
	Registra	ir	JUL 2	9 200	18 Marien	. 1%	6034	Es						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death edent's Name (First, Middle, Last) Month 0847 M **Physician** OX 21 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Chesapeake Hospice House Linthicum Anne Arundel 9. Birthplace (State or Foreign Country)
W. Va. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 24, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Months Min. Yrs. 721936 236-54-5817 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County works r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☑ No Director MD Calvert Owings 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9147 Woodland Way North 20736 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or Itel 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☑ No Specify: Saltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5 College (1-4or 5+) Safety Technician College traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be to Department of Health and Mental Limportant: If then 27 is more any injury or other. Be Joseph Shepard Eva (Unknown) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jerry R. Shepherd (son) 10830 Ward Road Dunkirk, MD 20754 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 28 1 Burial 2 □ Cremation 3 □ Removal from State Southern Mem. Gardens 2008 4 Donation 5 Other (Specify) Dunkirk, MD 22. Name and Address of Facility 21. Signature of Juneral Service Licensee Lee Funeral Home Calvert, PA Gary 20736 Goff 8125 Southern Maryland Blvd. Owings. MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Opeet and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on. Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sq. 2**X**No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy perform cers 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 6 Koker (Sbe 2 ER/Outpatient 3□ DOA Certification: To After this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Property Proctor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier

zeu)

State Registrar

CHAEL 32. Registra Signature 31. Date filed (Month, Day, Year) 2008

JUL

ame and address of persor

ed cause of death (Item 23a)

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			State C		eartment of Health and	Mental Hygi	ene g. No. 2008	25961	
			Registrar  1. Decedent's Name (First, Middle, Last)		ertificate of Death	2. Date of Death		3. Time of Death	
-	Physici /Medic	_	Harvey Maurice Stockma	n, Jr.			24 <b>7</b> 2008 Year	2:00 p <sub>M</sub>	
	Examin		4a. Facility Name (If not institution, give street and nu 2178 Pulm Point Road	mber)	4b. City, Town, or Location of De		4c. County of Death		
			5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Huntingtown  if Under 1 Year I If Under 24 H	s. 8. Date of Birth	Calvert		
	Funeral Director		219–20–4508 1™ 2□F	81 Yrs.	Months Days Hours Mi		Year) Cou	place (State or Foreign intry) MD	
ř.	0		Usual Residence of Decedent			12/20/1	.520		
	arylar show dat	_	10a. State 10b. County	10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	he Ma 28a-f	Director	MD Calvert	Hunt	ingtown				
	th with t 23a or 2 ust be n	al Dir	10e. Street and Number 2178 Plum Point Road		10f. Zip Code 20639		g. Citizen of What Cou U.S.A.	•	
36	J within 72 hours after death with the Maryland jiene. Jiene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	Armed Fo	2 □ No ive	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 ☐ Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: Wh		
5-0036	72 hou 'natura dical E	ted	15. Decedent's Education	16a. Dec	edent's Usual Occupation		6b. Kind of Business/I	ndustry	
בונ בונו	within 7 iene. than "n the Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (	life.	e kind of work done during most of w DO NOT use retired)	orking	Cale Days		
7	ifiled wi If Hygien other the rent, the	S	5		Carpenter		Self Empl	oyeea	
Maryiand	be od c	To Be	17. Father's Name (First, Middle, Last)  Harvey Maurice Stocks	man, Sr.		ame (First, Middle, M nie M. Rin			
a	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type. Print)	1	ling Address (Street and Number or	Rural Route Number,	City or Town, State, Z		
	s 1 and 2 f Health item 27 other tr		Mary Stockman-Wife		.78 Plum Point Ro				
<u> </u>	ot ite		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from	State 20b. Place of Disp	position (Name of ematory or other place)		Oc. Location - City or		
Baltimore,	it. Pa irtmen rtant: njury		4 □ Donation 5 □ Other (Specify)  21. Signator of Funeral Service I censee			04/2008	Cheltenha		
ра	permit. Page Department of Important: If any Injury or once.		Lisa M Counts		22. Name and Address of Facility B125 Southern Md				
F	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on					Approximate Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death)	(or as a consequence of):	CARDIOVA SCULA	ANEURY.	ראיז	MINUTE	
			h A The	o SCUEROTIL	CARDIOVA SCULA	MCIE S	34	YEARS	
	po tio	iner	Sequentially fiet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):			-		
	xecute and I-trans	Examiner	triat initiated events	(or as a consequence of):					
09/89	ficate be executed physician and sthe burial-transit		d	(					
200	- 07	edical	Ju						
7. BOX	The law requires that the death certificate I te has been signed by the attending physionege 2 should be detached for use as the land.	Physician/M	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year	
J Ö	that the sed by detacl		Part II. Other significant conditions contributing to c	leath but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
Hecords,	w requires that been signed b should be deta	ed by			PRUZTIVE PULMO	1 1 Ye	s 2 No 3 Pro	obably 4 Unknown	
ပ္ပ	law re as bee 2 sho	Completed	NARY DUFFE			24a. Was ar		topsy findings available ompletion of cause of	
_						perform	led? death? ☑No 1 ☐ Yes	2 □ No	
VItal	stcian: The certificate t rector, page	Be	25. Was case referred to medical examiner?		044	eath (Check only one			
0	Physical this cral direction	To	1 ☐ Yes 2 No Hospital: 1 ☐ 27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatie		Home 5 Reside	nce 6 Other (Spec	eify)	
0	nding th. : After e fune	tion		nth, Day Year) Injury		200. Describe no	w injury occurred		
DIVISION	r Atter	Certification:	3 Suicide 6 Could not be determined 28e. Place	e of injury - At home, farm, s ling, etc. <i>(Specify)</i>	treet, factory, office		eet and Number or Ru State)	ral Route Number,	
5	Ital or rs after ral DI led in	Cerl	4 Homicide building, etc. (Specify) City or Town, State)						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical	(Check only 2 Medical Examiner: On the I		ath occurred at the time, date and plain investigation, in my opinion, death o				
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Monti	n, Day, Year)	
1			Whit Ment	no	126358		TULY 28.	2000	
١.	. 2		30. Name and address of person who completed cau	se of death (Item 23a) (Type		, 0		_	
X	M J		31. Date filed (Month, Day, Year) 32. 1	2 M ) - PR	INCE FREDE	RICE. 1	13-206	78	
	Sta Registr		1111 2 9 2008	Registre's Signature	Sparke				

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			For State Registrar	State of	of Marylan		artment of F rtificate of		nd Men	tal Hygien	Z U U O	25962
74	Physicia /Medic	_	Decedent's Name (First, Middle AGNES	e, Last) T.	THOMPS	ON			1	Date of Death Month Da ULY 28	2008	3. Time of Death 6:15 A M
}	Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, o			40	. County of Death	
			NORWOOD MANOR  5. Social Security Number	GENESIS 6. Sex	7. Age (In yrs.	last birthday)	MILI If Under 1 Year	ERVILI if Under 2	24 Hrs. 8. [	Date of Birth	ANNE ARU  9. Birth	place (State or Foreign
	Funeral Director		216-60-9938	1 □ M 2 <b>X</b> F	55	Yrs.	Months Days	Hours		Month, Day, Year RCH 24	) Cou	TIMORE, MD
	nud »		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Maryla f shor	ļo				ADY SI						1 X Yes 2 □ No
	th the	)irec	10e. Street and Number	ARUNDEL		ADI DI	10f. Zip Code				itizen of What Cou	intry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show the than Medical Examiner must be notified at	Funeral Director		BEACH RO		0 10	20764	lianamia Onia	-in-2 (Conneits		14. Race - Ameri	ran Indian
	fter de r item iner n	Fune	11. Marital Status 1 ☐ Never Married 3☐ Mar	Armed F	cedent Ever in U. orces? 2011 No ive		Was Decedent of H if Yes, specify Cub		, Puerto Rica	n, etc.)	Black, White	, etc.
21215-0036	ours a	<u>ک</u>	3 ☐ Widowed 4 ☐ Divorced		ive** Dates:		1 ☐ Yes 2 ☐XNo	Specify:				ACK
15-(	n 72 h "natu edlcal	lete	(Specify only highe	it's Education st grade completed		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most d)	of working	1	Kind of Business/Ir	ndustry
212	y withing yiene.	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	INSU	RANCE AG	ENT			PRIVATE	
<u>⊆</u>	be do eve	To Be C	17. Father's Name ( <i>First, Middle,</i> JOHN DOWNS	Last)				18. Mother PA	r's Name <i>(Fir</i> ULINE	st, Middle, Maide	n Surname) PARKER	
	2 short and is m		19a. Informant's Name/Relations TABMADGE THOM		BAND	19b. Maili 1522	ng Address <i>(Street</i>	and Number BEACH	r or Rural Ro I ROAD	oute Number, City SHADY S	or Town, State, Zi IDE, MARY	ip Code) ZLAND 20764
Baltimore,	permit. Pages 1 and 3 Department of Health Important; If Item 27 any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □ Removal from			osition (Name of matory or other pla		Date		_ocation - City or T	
<u>H</u>	t. Pages rtment of I tant: If ite		4 □ Donation 5 □ Other (5	Specify)	R]		LE CREMAT  2. Name and Addre		7/30/2		VERDALE,	
Ba	permit. Departr Importa any inju		21. Signature of Funeral Service	1001011	d							20785
	-		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  7474 LANDOVER ROAD LANDOVER, MARYLAND  Approximate Interval Between									
1	hysician	8 1	Immediate Cause (Final disease or condition			VGTO	NIS	DISE	ASE			Onset and Death YEARS
-	/Medical Examiner		resulting in death)		(or as a conseq							
14		Je.	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause. Chisease or injury that initiated events resulting in death) Last									
	ate be executed hysician and he burial-transit	Examiner										
760,	te be executed ysician and te burial-transit	cal Ex	Due to (or as a consequence of):									
687	ficate physi s the b			d								
XO	h certi ending use a	M/u	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna		⊒Ectopic pregnanc	ev.			23d. Date of deli	
Vital Records, P.O. Box	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown		gnant at time of o		Other (specify)	· · · · · · · · · · · · · · · · · · ·			Month	Day Year
Д.	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?		
rds	w requires that been signed b should be deta	Completed by								1 🗆 Yes	2 No 3 Pro	obably 4 □Unknown
eco	law re as bee 2 sho									24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u>س</u> ۳	siclan: The law s certificate has t irector, page 2 s									performed? 1□ Yes 2 1	death?	_
<u> </u>	siclar certifi irector	) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	Inpatient 2	EB/Outpatio	nt 3 DOA Ot	hor: 4.		heck only one)	6 □Other (Spec	260
יס ר	Attending Physician: r death. ector: After this certifici	n: To	27. Manner of Death	28a. Date	e of Injury onth, Day Year)	28b. Time of Injury	of 28c. Inju			Describe how in		ary)
sior	tendin eath. Ior: Af the fur	catio	Z Accident	igation			M 1	Yes 2 l				
Division or	I or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						rai Houte Number,			
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only 2 Medica	ng Physician: To the I Examiner: On the and ma	ne best of my kno basis of examina inner stated.	owledge, dea ation and/or i	th occurred at the t nvestigation, in my	time, date an opinion, dea	nd place, and ath occurred a	due to the cause at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29d.						29d. [	. Date signed (Month, Day, Year)		
	1	1	1 Omil	will	In	<b>u</b> )	D3	31136		Ju	LY 28,	2008
1	(b)		30. Name and address of person	who completed car NALLAC	use of death (Iter	m 23a) (Type	, Print)	0:05	e a	Barris	10115 10	2008 m 2(236
	Sta	ite	31. Date filed (Month, Day, Year	32.	Registrar's Sign	ature	ILLD	~ 1 70	12/	DATUL IN	.0,00	W CICJAS
	Regist		JUL 3 0 2008	Kenne	X A	men						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 27, 6:15 JULY 2008 NORMA ANNA JEANETTE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles LaPlata Genesis Elder Care If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** Months 1 □ M 2 🛣 F 01-13-1937 Philadelphia.PA Director 71 180-30-5665 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County iral", or Items 23a or 28a-f show Examiner must be notifled at 1 1 1 1 No Bryans Road Directo Marvland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20616 USA 5858 Wolsey Court East Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: Specify: 3 Widowed 4 Divorced Black "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) +02 Elementary/Secondary (0-12) 12th than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the M Private Industry Seamtress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlotte Davis Howard Weaver, Sr. မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5858 Wolsey Ct. East Bryans Road, MD 20616 Eugene Townes/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Mem. Cemetery | 07-31-2008 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mo1246 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No has le 2 page this certificate 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my oninion, doubt accurred at it. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

01-2)

State 31. Date filed (Month, Day, Year)

Registrar

JUL 3 0 2008

Post Office

2d. Sicile # 101 Waldorf

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

0006165

Mg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of F rtificate of			ne No. 2008	
- 48 	Physicia	an	Decedent's Name (First, Middle, Las     Doretha		S		2	2. Date of Death Month July 1	Day 2008	3. Time of Death 7:10 A. M
	/Medic Examin	and the same	the Charles of Doth						4c. County of Dea	
			Manor Care of Wl			Wheat of Under 1 Year		Data of Dieth	Montgo	
	Funeral Director		217-30-3333	x	n yrs. last birthday) 1 Yrs.	Months Days		B. Date of Birth (Month, Day, You Septembe		thplace (State or Foreign ountry) Maryland
	land ow	-	Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or Lo	ocation				10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	Maryland Montgo	omery	Whea	ton				1 X Yes 2 □ No
		Funeral Director	10e. Street and Number			10f. Zip Code	20	"	. Citizen of What C	•
		eral	11901 Georgia Av	7enue 12. Was Decedent Eve	er in U.S. 13.	2090 Was Decedent of H	JZ lispanic Origin? (Spec an, Mexican, Puerto R		nited Sta 14. Race - Am	erican Indian,
21215-0036	ours after or ral", or Iter Examiner	þ	1 □ Never Married 2 □ Married 3 🛣 Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puerto R  Specify:	ican, etc.)	Specify: B	
5-0	"natu	letec	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual Occup	nation during most of working d)	9	b. Kind of Business	/Industry
121	within iene. than the Me	Completed	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+)	I	rse's Aic	•		lenn Dale	Hospital
<u>Б</u>	e filed al Hyg other vent, i	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name		•	
ylaı	ould b Menta arked	To E	Lawrence Tabl				Frances	Pierc		
Maryland	d 2 sh th and 7 Ism traum		19a. Informant's Name/Relationship (7)  Larry Edward McE		l	,	and Number or Rural est Lane; \	•		•
ē,	s 1 and f Healt frem 2 other		20a. Method of Disposition		20b. Place of Dispo cemetery, cre-				c. Location - City o	
Baltimore,	Pages nent of nt: If I		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemovai from State	/		nal Cemeter	-	Suitland,	Maryland
alti	permit. Departm Importa any inju		2) Signature, 1 uneral Service Lorin	9ee //	1		ess of Facility Tton Compar		_	
10	205 20		Tandaph	5.740		600 Kenne	edy Street	, N.W.;W	ashington	n, DC. 2001  Approximate
	Physician /Medical	8 8	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death							
			disease or condition resulting in death)	a. Uroseps						
	Examiner		Companielly list conditions	Diabete						
	sit sd	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that initiated events	Due to (or as a c	consequence of):					
•	cate be executed physician and the burial-transit	Examine	that initiated events resulting in death) Last	cDue to (or as a c	consequence of):					
8760,	ficate be executed physician and s the burial-transit	dical	<b>5</b>							
	rtificat ng phy as th	9 1	IF FEMALE:							
.O. Box	the death certific y the attending p ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date of de Month	elivery Day Year
σ.	that the de led by the a detached f		Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
rds	v requires been sign should be	ed by	Hypertension 1   Yes						2  No 3 □ Probably 4 □Unknown	
Records,	The lay ate has page 2	Completed	Stroke					24a. Was an autopsy	prior to	autopsy findings available completion of cause of
<u> </u>								perform 1 Yes 2	d? death? No 1 ☐ Ye	s 2 No
Vita	Physician: Th this certificate al director, paç	Be c	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital:	2.□ EB/Outpotio	nt 3 DOA Oth	26. Place of Death	, , , , , , , , , , , , , , , , , , , ,		
ō		7: To	27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	III 3 DOX	441 Nursing Hor	e 5 ∐ Hesiden 8d. Describe how	ce 6 Other (Sp injury occurred	ecity)
ion	att att	atio	1 Natural 5 Pending investigation		(ear) Injury		Yes 2□No			
Division or Vital	tal or Atten rs after death al Director: ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Medical (	(Check only 2 Medical Exar	ysician: To the best of r niner: On the basis of ex and manner state	xamination and/or in	nvestigation, in my	opinion, death occurre	ed at the time, dat	e and place, and de	ue to the cause(s)
	To To	Σ	29b. Signature and title of certifier	$\mathcal{C}$		29c. Licens	se number 058962		d. Date signed (Mor	
ř	- 1		20 Norse of Little	completed source of data	th (Item 22a) (Turn				July 24	, 2008
į.	ID		30. Name and address of person who Shashank G. Pate.				e;Suite 10	3; Olney	, Marylar	nd 20832
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature					
	Regist	-	JUL 2 5 2008	32. Registrar's	quere	<b>,</b>				
DHI	MH 17 Rev 1/2	001	AT .							

State Registrar SURESII

DHMH 17 Rev 1/2001

11701 LIVINGSTON

ROAD,

SUITE # 101, FORT WASHINGTON MD20749

30. Name and address of person who completed cause of death (It in 23a) (Type, Print)

2008

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of State of Registrar	•	epartment of F		, ,	giene Reg. No $2008$	25966
	hysicia		1. Decedent's Name (First, Middle, Last)  Lois Jean William	ns			2. Date of Dea		3. Time of Death
7	/Medic Examin		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or	Location of Death	34//	4c. County of Dea	
Fi	uneral	-	Doctor's Community Hospi 5. Social Security Number 6. Sex 7	tal 7. Age (In yrs. last birth	Lanhar hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	Prince Ge	thplace (State or Foreign
	rector		577-58-2623 1□ M 2□XF	64 Y	rs. Months Days	Hours Min.	July 9,		co, Texas
yland	wow #		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
he Mar	28a-f s	Director	District of Columbia  10e. Street and Number	Wash	ington 10f. Zip Code			10g. Citizen of What Co	1 Yes 2 No
h with t	3a or	al Dir	529 Quincy Street, NW			011		United S	
er deatl	tems 2	Funeral	11. Marital Status 12. Was Deced Armed Ford		13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No- Rican, etc.)		erican Indian,
5-UU30 72 hours after death with the Maryland	al", or i	by	1 ☐ Never Married 2 💢 Married 1 ☐ Yes 3 3 ☐ Widowed 4 ☐ Divorced Year or Da	9	1 □ Yes 2 No	Specify:		Specify:	Black
15-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	11 /	Decedent's Usual Occup	turing most of work	ing	16b. Kind of Business	/Industry
d Z1Z1 filed within Hygiene.	It man	dmo:	Elementary/Secondary (0-12) College (1-12 years		life. DO NOT use retired cupational	<sup>y</sup> Recreati <u>Therapist</u>	1	Govern	ment
and d be filed ental Hy	e d d	Be	17. Father's Name (First, Middle, Last)		-	18. Mother's Name	e (First, Middle,	Maiden Surname)	
narytand 2 should be fi 1 and Mental H	marke	မ	Walter Sharpe  19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street		Mae C1		Zip Code)
e, Ma and 2 sl lealth an	m 27 is ner trai		Harry L. Williams - Hus	band 52	9 Quincy St	reet, NW	Washing	ton, DC 200	011
Pages 1	– T ⊕ <del>=</del>	14	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S	tota   cemetery	Disposition (Name of y, crematory or other plac y Mem Park	e)	Date 31 , 200	20c. Location - City or 8 Landove:	
Saltimor bermit. Pages Department of	Importan any injur once.		4 □ Donation 5 □ Other (Specify)  21. Sig. ature of Funeral Service Library	MI	22. Name and Addres			Funeral Ho	me, Inc.
n eğ	트뉴정	-	23a. Part . Boter the disease, or complications that ca	used the death. Do o				hington, D	C 20019 Approximate
- Phys	sician	3	shock on eart failure. List only one cause on ea Immediate Cause (Final disease or condition	or line.	0		or respiratory an	1651,	Interval Between Onset and Death
/Me	edical miner		resulting in death)	or as a consequence of		(man,			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter funderlying Cause, (Disease or injury	or as a consequence of	f):				
xecuted	and I-transi	Examiner	that initiated events .	or as a consequence of	f):				
. <b>BOX 5875U</b> , death certificate be executed	physician and the burial-transit	dical E	d	T ab a concequence of	.,,				_
X 08 Sertifica	ding ph	Med	IF FEMALE:	ome of pregnancy					
death cer	ne atten	hysician/Me	in the past 12 months?  1 ☐ Live b  1 ☐ Yes 2 ☑ No	irth 2 Fetal death ant at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of de Month	Day Year
that the	ed by the	۵	9 ☐ Unknown  Part II. Other significant conditions contributing to dea		the underlying cause give	en in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
COTOS,	en sign	ed by	Coronary Aske	my Die	sea		1 🗆 Y	∕es 2, <b>5</b> 1 No 3 ∏ F	Probably 4 Unknown
Hecc	has be e 2 sho	Completed	Diabetes, M	ellitus			24a. Was autop	an 24b. Were a	utopsy findings available completion of cause of
VITAI P Iclan: Th	tificate or, pag		25. Was case referred to medical			26. Place of Deat	1 □ Yes	rmed? death? 2. StNo 1 □ Ye	s 2□No
OT VI Physicia	this cer	To Be	examiner?	npatient 2 ER/Out	tpatient 3 DOA Other	OF:		dence 6 ☐ Other (Sp.	ecify)
ding P	After t		La rate a la chang		njury Worl	yat <br Yes 2 □No	28d. Describe h	now injury occurred	
UIVISION I or Attending after death.	within 24 bours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, fari g, etc. <i>(Specify)</i>	m, street, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
Spital o	filled ir		29a. Certifier 1 to the 29a. Certifying Physician: To the	best of my knowledge	, death occurred at the tir	ne, date and place.	and due to the	cause(s) and manner	as stated.
the Ho	the Fu	Medical	(Check only one) 2 Medical Examiner: On the ba						
P T	<b>6</b>		29b. Signature and title of certifier	Sige	29c. Licens			29d. Date signed (Mon 7- 24-	in, Day, Year) - OS
26	5)		30. Name and address of person who completed cause	Tfex	Type, Print) PIND	EK SINGA	cie	7-24- 7:24-	e)15
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 2 8 2008  Signature	egistrar's Signatur	E .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day John T. Williams a M July 28th 2008 2:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Riverdale
| If Under 1 Year | If Under 24 Hrs. | S. Date of Birth (Month, Days, Year) | 09/19/19/57 Crescent Cities Center Prince George
9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, North Carol 578-78-8339 50 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Capital Heights Md Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26 Capital Heights Blvd 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Pvt Industry 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruthie Mae Williams Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 19a. Informant's Name/Relationship (Type. Print) Clarence Williams(Brother) 26 Capital Hghts Blvd, Capital Heights Md 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale Pk Crem :07/30/2008 Riverdale Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funer Service Licen 20011 NW WashDC Tyrone J. Young 719 Kennedy St. 23a. Part 1. Ziter the disease, o shock, of heart failure. List Immediat Lause (Final Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest VIRUS uman Immunodetickny Yeary disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any land to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Waş an autopsy perform 2 🗖 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, signed by the a o ٦. Division of Vital Records, been s cate has I page 2 s certificate this

**Physician** 

/Medical

Examiner Physician/Medical

**Physician** 

/Medical

Examiner

Funeral Director

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventual by rottlind at another.

Baltimore, Maryland 21215-0036

Completed by 25. Was case referred to medical examiner? Be ical Certification: To neral Director: After the filled in by the funeral 27. Many er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

23 Quelis Sury all Hyatts Ville M& 20081 DEVUCE MO

Name and address of person who completed cause of death (Item 23a) (Type, Print)

D01852 Tucy 28 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** DAVID 20, WILLIAMS JULY 2008 3:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death PRINCE GEORGE'S 1615 VILLAGE GREEN DRIVE LANDOVER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day Year) JULY 22 1938 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1₩ 2□ F VIRGINIA Director 231-50-1135 Yrs Usual Residence of Decedent the Marylend 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits worde r then "naturel", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at Be Completed by Funeral Director 1♥Yes 2□No PRINCE GEORGE'S LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20785 1615 VILLAGE GREEN DRIVE death 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No POST— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 1□Yes 2√No If Yes, Give Year or Dates: **-KOREAN** Specify: SpecifyBLACK 3 ☐ Widowed 4 🖸 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 YRS PRIVATE ENTREPRENEUR nd 2 should be filed lith and Mental Hygid 27 le marked other r treumatic event, III Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If tem 27 1e marked any injury or other treumatic events. **ESSIE** WHITE BERT BROWN ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SEAWRIGHT/DGT 7319 SHERIFF ROAD LANDOVER, MARYLAND 20785 STEPHANIE Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY CEMETERY 7/25/2008 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760 attending physicien for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown cete has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KIDNEY TRANSPLANTATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 Yes 2**₩** No 1 Yes 2 No director. Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation To the numbers after death.

Vithin 24 hours after death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MD# 33255 JULY 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., VAMC,50 IRVING STREET NW, WASHINGTON, DC 20422/688 KAREN ANN BLACKSTONE, 31. Date filed (Month, Day, Year) State JUI 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25969 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death July 2008 20 3'45 PM Sharon Louise Williams 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Doctor's Hospital Lanham Prince Georges' If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 🔽 F Months Days Hours Min 214-60-3442 56 Yrs 4/26/1952 Washington, D.C. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location XXYes 2 □ No PG Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1812 Barry Lane 20747 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritai Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 🔀 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Manager D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry H. Hall, Sr. Elsie I Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel M. Herring - Sister 1812 Barry Lane; Forestville, Maryland 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 07/28/2008 Beltsville, Maryland re of Funeral Service Line 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 23a. Part . Enter the disease, or co shock, o heart failure. List onl Immediate Lause (Final pications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ON 1 disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ITIS OF SACRUM 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 D Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?

**Physician** /Medical Examiner

Health a

**Physician** 

Examiner

**Funeral** 

Director

and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene.

Baltimore, Maryland 21215-0036

ed other than "natural", or Items 23a or 28a-f sho event, the Medical Evaniner must be notified at

/Medical

Directo

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Completed

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Examine Physician/Medical δ Completed Be s after dec... ral Director: After ... Certification:

The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi

certificate

this

or Attending Physician:

To the Hospital o within 24 hours af To the Funeral Di

Division of Vital Records, P.O. Box 68760,

IF FEMALE:

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1□Yes 2XNo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident

and manner stated.

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Da 20770

ompleted cause of death (Item 23a) (Type, Print) BILAH MO HANDYER PARKWAY SUITE IOIA GREENGELT, MI) DKD 1500

31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

32. Registrac's Signa

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month **Physician** Year Christina Wise-Mohr 24, 9:15 a M July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2932 Woodstock Avenue Montgomery Silver Spring 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🗙 F Director 215-50-4842 59 June 1, 1949 California Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 🔀 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2932 Woodstock Avenue 20910 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2x No 1 Never Married 25 Married Specify: White 1 ☐ Yes 2 ☐ No Completed by 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Senior Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd Crowell Joan de Jong ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter J. Mohr/Husband 2932 Woodstock Avenue, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 remation 3 ☐ Removal from State July 29 2008 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that cause leadeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician a Multiple Sclerosis /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Flaccid Quadriparesis, Bulbar Palsy 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2X No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 🛣 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral C 1 Cacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37643 July 25, 2008 D me and address of person who completed cause of death (Item 23a) (Type, Print) #233 omas M. Hyde, MD 4701 Willard Avenue, Chevy Chase, MD 20815 Thomas M.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2008

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Division of Vital Records,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY RAYMOND LIONEL WATSON 22, 2008 3:15 P<sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours Months 1 XM 2 ☐ F Yrs. 579-94-5562 37 11/26/1970 DC Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Prince George's Oxon Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5422 Livingston Terr. #302 20745 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th unemployed 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) George Marshall Diane Hackett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3711 Endsley P1 Upper Marlboro, MD George Marshall/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crem Alexandria, VA 7/30/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home Signature 4217 9th Street, NW Washington, DC 20011 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final dai disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 Other (specify) TYes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 Yes

**Physician** /Medical Examiner Examiner

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attending pl

been signed by the should be detached

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After thi funeral

l Director: A

or Attending Physician:

death

after

To the Hospital o within 24 hours aft To the Funeral Di completely filled in

Physician/Medical

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Completed

Be

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Certification:

Medical

State

The law requires that the death certificate be executed

Box 68760,

P.0.

of Vital Records,

Division

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

MD

**Funeral** 

Director

show

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modical Examinar must be notified at

within 72 hours after

I and 2 should be fi Health and Mental H

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum

Maryland 21215-0036

altimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

25. Was case referred to medical examiner? Hospital Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 No 1 Tes 27. Manner of Death 1 Natural
2 Accident

3 Suicide

4 Homicide

5 Pending investigation

Date of Injury (Month, Day, Year) 6 ☐ Could not be

and manner stated

28b. Time of Injury

28c. Injury at Work? 1 ☐Yes 2 ☐No

28d. Describe how injury occurred

10 CENTER DRIVE, BETHESDA, MARYLAND

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

0101243203 (VA)

20892

HANS ACKERMAN, M.D.

31. Date filed (Month, Day, Year) 32 Registrar's Signature 2008



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Evelyn Marie Wood July 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 2740 Solomons Island Road Calvert Huntingtown r 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2**X**F Months Days Hours Director 219-48-9141 92 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 2740 Solomons Island Road 20639 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ¼ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by 3 ₩ Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home t of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Cephas Buckmaster Louise Hardestv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin G. Wood, Sr., son 2990 Solomons Island Road, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
important: if iter
any injury or oth 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Mem. Gardens 07-30-2008 Dunkirk, MD 20736 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. William 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical the use as yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 20 1 Live birth 2 Detail death 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2010 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2≥1No 10 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed physician and s the burial-transit attending signed by the a has this certificate

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

lew 15

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and defess of person who commend cause of death (Item 23a) (Type, Print)

Jonathan Lowenthal, M.D., 10845 Town Center Blvd., Ste. 204, Dunkirk, MD 20754

31. Date filed (Month, Day, Year) 32. Registrans Signature 2 9 2008 JUL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 4:48 PM **Physician** ISELL 2008 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 374/timore HEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 217-34-7643 1 ☐ M 2 🗷 F 70 11937 North CAROLINA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, its Modice Examinat must be notified a 1 XYes 2 □ No Director TIMPLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number EAST POELTON STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify ð Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, Its Mo Elementary/Secondary (0-12) College (1-4or 5+) JOMEST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HENRY BELL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NIEUE 4709 Dunkirk AVENUE BAITMORE MO MYIAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 11-08 8-JETTO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3436 W. FORE ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WD 31716 BAIDO Approximate Interval Between Onset and Death Immediate Cause (Final yerrs **Physician** CATCINOMA lung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the burial-tran and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Ö certificate has been signed by the rector, page 2 should be detached 9 Unknown σ. 23e. Did tobacço use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 **N**0 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Fother (Specify) Hospice 1 Yes 2 ₩ 10 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8.10.08

State Registrar

DHMH 17 Rev 1/2001

301 ST PAUL BALT MD 21202

cui

1111 32. Registrar's Signature

w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 1 3 2008

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Division of Vital Records, P.O. Box 68760,

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			For State Registrar	Otate of Maryland /	Certificate of Death		
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	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location	110.01000	4c. County of Death
2			5. Social Security Number 6. Sec	TION EXTENDED CA	hirthday) If Under 1 Year   If Under	24 Hrs. 8 Date of Pitth	O Dirthplace (Clate or Family
	Funeral Director			7. Age (In yrs. last	Yrs. Months Days Hours	Min (Month, Day, Yea	9. Birthplace (State or Foreign Country) MACY) AND
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Expedient contacts of a facilities of		10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if it is Micheal Experiment has been cliffed at	Director	MAMIAND BAITIA	roce E	SOBMEDER		1 X Yes 2 No
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9	or iter		1 Never Married 2 Married	Armed Forces? 1 ■Yes 2 □ No If Yes, Give	If Yes, specify Cuban, Mexical  1 ☐ Yes 2 ☑ No Specity.	n, Puerto Rican, etc.)	Black, White, etc.
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	e filectal Hyg	Be C	17. Father's Name (First, Middle, Last)	. 0 .		er's Name (First, Middle, Maid	en Surname)
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Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (T)		9b. Mailing Address (Street and Numb	per or Rural Route Number, Cit	y or Town, State, Zip Code)
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Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other trope.		21. Signature of Funeral Service Licens	- OALL IO	22. Name and Address of Facili		Wings Mills MANJANON
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			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the death. Ene cause on each line.	o not enter the mode of dying, such as	s cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
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Box (	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
Э.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl 9 ☐ Unknown			Month Day Year
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Records,	signed be det	d by	Fait II. Other significant conditions co	minibuting to death but not resultin	g in the underlying cause given in Part	1. 23e. Did tobacc	
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Re	he law te has age 2 s	duc				autopsy performed	prior to completion of cause of death?
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	ilng P.  After t	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	o. Time of 28c. Injury at Work?	28d. Describe how in	
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	To th withir To th comp	Me	29b. Signature and title of certifier	T 0, 0	29c. License number	29d.	Date signed (Month, Day, Year)
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	3		30. Name and address of person who con AUROPA C, TAN	3900 LOCH R	a) (Type, Print) AVEN BOULEVA	RD, BALTIM	WRE, MD 2/2/8
	Sta Registr		31. Date filed (Month, Day, Year)	22. Registrar's Signature	Acres 10 a		ı
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 2220 Argust 2008 DARcella BARNES 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore of Maryland Medical System University If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 🛠 🗆 F 4-5-1969 39 MD 218-84-4805 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 2934 Round Road 21225 USA 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 → Married 1 ☐ Yes X☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Lorien Frankford Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home G N A 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie Stanford Theresa Spence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Amanda Coleman -Daughter 936 Jack Street Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cem 8-18-2008 Anne Arundel Co, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H MD 21202 E. North Avenue Balto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final carried with

Physician /Medical Examiner

Department of Health a Important: If Item 27 is any injury or other trainonce.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Funeral Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

\* Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. \* Funeral Director: After this certificate has been signed by the attending physician and stell filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,  $\overset{\mathcal{L}_{\mathcal{C}}}{\diamond}$ 

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that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome pf pregn: 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	al death 3 Ectopic	pregnancy (specify)		23d. Date of delivery  Month Day Year			
Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	g cause given in Part I.		use contribute to the cause of death? □ No 3 □ Probably 4 ▼Unknown			
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No			
25. Was case referred to medical			26. Place of De	ath (Check only one)				
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Kalinpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)			
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3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	tory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)				
29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurration and/or investigation	red at the time, date and plaction, in my opinion, death oc	ce, and due to the cause( curred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)			
29b. Signature and title of certifier			29c. License number	29d. D	29d. Date signed (Month, Day, Year)			
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Greene Street

Baltimire MD 21201

State Registrar 31. Date filed (Month, Day, Year)

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To the Hospital or within 24 hours aft To the Funeral Di completely filled in

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Bumbreu Month Day  $\mathbb{Q}$  . Julia **Physician** 1:18 August 2008 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | Month, Day, Year) | 7-17-1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🖵 F 76 S.C. 215-24-7793 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 3a or 28a-f shov t be notified at 1 Yes 2 No Director N/A MD Baltimore 10e. Street and Number 10f. Zin-Code 10g. Citizen of What Country? Items 23a 21218 1124 Montpelier Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Black 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No þ Specify Specify 3√2 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade Disabled Disabled .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Item 27 Is marked other I jury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dinkins Felder Tora King ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MB1117 Department of Health a Important: If Item 27 Is any Injury or other trace Sierra Circle Apt K Owings Mills, Lisa Bumbrey-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Y Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Μt 8-15-2008 Carmel Cemetery Balto, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H Y ane 1101 E. Balto, MD North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ventri cular **Physician** tachycardia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) physician as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2☐ Fetal dea ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 TYes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed' 2 🗌 No 2. No 1 Tyes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation Injury 1 Yes 2 No r death, 2 Accident the ector: Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide City or Town, State) within 24 hours at To the Funeral D completely filled it 29a. Certifier Lexcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) August 10,2006 0066521

State Registrar 31. Date filed (Month, Day, Year)

MARYAM

SAT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TAR

DHMH 17 Rev 1/2001

MD

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25977 State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2008 John Nelson Balch Jr 5:36 P M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) Aug. 21, 1930 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1⊠M 2□ F 77 Tennessee Director 411-48-3297 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Injury or other traumatic event, the Medical Examinar must be notified at Frederick MD Frederick 1 ☐ Yes 2X No Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or Pages 1 and 2 should be filed within 72 hours after death with United States 5659 Crabapple Drive 21703 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) Computer Specialist U.S. Government of Health and Mental Hygi Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Alberta Sanborn John Nelson Balch, Sr. ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5633 Crabapple Drive, Frederick, MD 21703 Erma Irene Balch/Wife 20b. Place of Disposition (Name of cemetery, cramatory or other place). Wash. University August 8 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) 2008 Medical Center 21. Signature of Funeral Service Lic 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Rd. Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation neral Director: A filled in by the fi 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifi

PICKERS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WID

2008

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

5,

00 egistrar's Signature 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician mg ust /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** altmore Sugurs 405PHal N/A If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. XXM 2□ F Yrs. SEPT 29 MARYLAND 216-28-4108 77 1930 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at 1 XYes 2 □ No Director BALTIMORE MARYLAND N/A 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21217 U.S.A. 1219 N. GILMOR ST. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BETH STEEL 7th grade RIGGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H f Item 27 is marked ott Be EDWARD DICKIE EDITH HOWARD ဂ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tragonce. 1219 N. Gilmor St., Baltimore, Maryland 21217 Carolyn Johnson/Daughter Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) WOODLAWN CEMETERY 08-18-08 WOODLAWN, MARYLAND 21. Sign or e of Fuperal Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Webara Cos Moun 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** atheroscente cardiovasalar discase disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if one line line cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial-tran P.O. Box 68760, Cerebro Vasans a IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown adeno carcinomo 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 **1** Mo 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Cort,

2008

31. Date filed (Month, Day, Year,

Bon Secours Hospital. 2000 W. Baltimore Steet, Baltimore MD 21223

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:40 P M 08 BURNETTE 2000 CARLENE 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BA SAMARITAN 6000 HOSPITAL LIIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗓 F NORTH CAROLINA Director 241-84-1334 NOV. 20 1946 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f shoi other traumatic event, the Medical Examinar must be notified at 1XXes 2 □ No Director BALTIMORE MARYLAND 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiené.
Int: If item 27 is marked other than "natural", or items 23a or ? U.S.A. 4305 ROBERTON AVENUE 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. MXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 🗓 No If Yes. Give Specify: 3 Widowed 4 Divorced BLACK Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WALMART CASHIER/STOCKER 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ADA PERRY BURNETTE MACK BURNETTE ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3203 Mossdale Ave., Durham, North Carolina 27707 Carrie Burnette/Sister 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of P
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAPEL HILL MEM GRDN\$ 08-14-08 CHAPEL HILL, N.C. 21. Sign we of Funeral Service License 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Darbaja CDlown 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician EREBRAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** BRAIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit MYXARDIAL Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑No P.0. ed by the a detached f 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown HY PERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours atter death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 29a, Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVEN WIEL HAKIM 601 21239 31. Date filed (Month, Day, Year) AUG 1 3 2008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 14 Physician Month BEVERLY 2008 10 DIAME /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner 1-LOSPITAL dalls BOITIMURE lown THWEST 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Number **Funeral** 46-891 Months Days Hours Min. 1 ☐ M 2 🗙 F Director 6 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Yes 2□No Completed by Funeral Director Imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 12. Was Decedent Ever in U.S. Armed Forces?. 1 ☐ Yes 2 (VNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced "natural"; er than "natura", the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) TaTe ndary (0-12) College (1-4or 5+) Elementary/Se Health and Mental Hygiene. em 27 is marked other than other traumatic event, the M Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be ma inl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a-Informant's Name/Relationship (Type. Print) RS HTKINSON dAUG 3626 Bellmore Balto 96b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20ç. Location - City or Town, State permit. Pages 1
Department of F
important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Segmation 3 ☐ Removal from State netro 4 Donation 5 Dother (Specify) 21. Sign up of Funeral Service Licensee 22. Name and Address of Facility BERTY 9 170 170. NA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MEDMONIA /Medical Due to (or as a consequence of): Examiner ARR HOSIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed HEPATIL sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has been si rector, page 2 should! 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No Medical Certification: To 1 ☐ Yes 1 🕅 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 TYes 2 □ No within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) this m.O 4)410 AUGUST 10 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER MÊ 32. Registrar's Signature SWHERING 31. Date filed (Month, Day, Year) State 3 2008 Registrar AUG 1

08-06036 UNK UNK

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 25981

		1- For State Registrar	Cert	tificate of	Death			Reg. No.	200	
Physicia	an/	1. Decedent's Name (First, Middle,Las	t)	· · · · · · · · · · · · · · · · · · ·			2. Date of De Month	ath Day	Year	3. Time of Death
al Exami	ner	Linda Jean Ba					August 7	, 2008		1239 hrs
		4a. Facility Name (if not institution, give	e street and number)	4	b. City, Town, or	Location of D	Death	4c. Cou Cecil	unty of Death	
		306 Conowingo Road			Conowingo	- Lirana a	due la partir			the lane (Cinta or
Funeral Director		5. Social Security Number 6. Social Security Number 16. Social Security Num	1,0	st birthday)	If Under 1 Year Months Day	<del></del>		25/195	Enroin	thplace (State or
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×.		Usual Residence of Decedent  10a. State 10b. County	Inc. City	Town or Locati	00					10d. Inside City Limits
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Maryland 28a-f show 1 at once.	ġ	10e. Street and Number	Ialk	VIIIE	406 7:- Codo			10g. Citizen o	of Minet Cou	
Mar r 28a	Director	3107 Californi	α Δνα		10f. Zip Code 21234			U.S.A		iu y r
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ith wi	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?				? ( Specify Yes or Nuerto Rican, etc.)	١	White, etc.	ican Indian, Black,
er dea			1 Yes 2 No	1	Yes 2 No	s specific		Sner	whi	te
rs aft ural"	ē	15. Decedent's Education (Specify o	1 or Dates:		t's Usual Occupa		d of work done		of Business/	
2 hou "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life					
36 thin 7 than than	힐	8		House	Keeper	•		Self	-Emp	loyed
5-0036 led within 77 Hygiene. other than	힝	17. Father's Name (First, Middle, Last John Richard B					Name (First, Middle			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	John Richard B	rown			Joann	n Leona	Jenki	ıns	
	ပ	19a. Informant's Name/Relationship ( John Richard B	rown/Father				er or Rural Route N			
e, MD Tand 2 sho Health and item 27 is							Ave, Ba			
or Heal		20a. Method of Disposition  1 Burial 2 Cremation 3		Place of Dispos rematory or oth	ition (Name of ce ner place)		Date		ation - City or	
Pages nent o		4 Donation 5 Other Specify	T Ch	esape	ake Cre	em.   8	3/12/200	)8 Be1	Ltsvi	11e, MD
Baltimore permit. Pages 1 a Department of He Important: If it		21 Signature of Funeral Service Lice		12 22. N	lame and Addres	s of Facility (	CAFA/Ste	phen	D Lo	hrmann P.A
<b>00</b> 8 9 1 1 1 1		Juda She	Kitter	ا 87 <del>ا</del>	17 Gree	en Pas	stures I	r. To	owson	,MD,21286
hysician		23a. Part Nenter the disease, or comfailure. List only one cause on e		Do not enter the	ne mode of dying	, such as card	diac or respiratory a	rrest, shock, o	or heart	Approximate Interval Between Onset and
Medical Examiner			Multiple Injuries							Death
		or condition resulting in death)	Due to (or as a consequence of	):						1
	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	·):	<del></del>		.=			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated								
ted nsit	Exa	events resulting in death) Last	Due to (or as a consequence of	):						
executed an and al - trans	cal	UNPENDED	AMENDEDItem#1,as	notat	od norMi	F C882	8/13/08	WC.		-
	/Medical	IF FEMALE:	23c. If yes, outcome of pregr		ed, perm		,0/13/00,		ate of deliver	<u> </u>
187 (rtifica	Ju /	23b. Was decedent pregnant in the past 12 months?	1 Live birth		tal death 3	Ectopic p	regnancy			Day Year
Box 68 death certif the attending	sician	1 Yes 2 No 9 Unknow	4 Pregnant at time of de	ath 5 Ot	her (Specify)					
O. Box 687 at the death certific d by the attending p	Phys	entrangentales and the rest	S Carnetown	Tr. 1 4	I I i a a a a a a	of an in Book	1 22a Die	dahaasa waa	contribute to	the sause of death?
, P.O.	by F	Part II. Other significant conditions	contributing to death but not re	esulting in the l	inderlying cause	given in Part				the cause of death?
S, F							24a. Wa			utopsy findings available
Records, The law require	Completed						aut	opsy formed?		completion of cause of
Rec The la cate h	E							2 No	1 ✓ Y	'es 2 No
tal Rec cian: The certificate ector, page	Be	25. Was case referred to medical examiner?			26.Plac		heck only one)			
of Vital  ng Physician  ther this cert  meral directo	T0 E	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient			Nursing Home 5		6 🗸 Othe	er: Scene
		27. Manner of Death  1 Natural 5 Panding	28a. Date of Injury (Month, Day, Year) Aug 7, 2008	28b. Time of I 1239 hrs		ury at Work?	Driver in v	e how injury o ehicular a		
Sior Attend death ctor: y the	atic	2 ✓ Accident Investigar	tion			Yes 2 ✔ N				
Division tal or Attendi rs after death. al Director: /	Certification:	3 Suicide 6 Could no determine	A CONTRACTOR OF THE CONTRACTOR			building, etc.	or Town	, State)		ural Route Number, City
Di Hospital 24 hours a Funeral I		4 Homicide	I I I I I I I I I I I I I I I I I I I					ngo Road, (		
the He in 24 he Fu pletely	Medical	(Check only Certifying Physic	ian: To the best of my knowledger: On the basis of examination a							
To the within 2 To the complet	Ned	29b. Signature and title of certifier	and manner stated.			se number				onth, Day, Year)
		10 ~ 00	ALL S			.M.E.			t 8, 2008	,,,,
. ~		( the lule	U'Y)	220)						
6		30. Name and address of person who Laron Locke MD. Assis	stant Medical Examiner		Street, Balti	imore, MD	21201			
<i>y</i>	tate		32. Registrar's Signatu		-					
Regis			2008 Magree	& lo	ask)					

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month tugust Physician 07:21AM Duckne 2008 10111 /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MARY Dalhmore Baltimore Harbor 1703 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 2 Month, Day 950 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗗 F Marvland 234-80-2742 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location I 0a. State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be inclified at MD Baltimore 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 21230 U.S.A. 135 1/2 W. Montgomery St Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) filed within Hygiene. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) 2 should be fil and Mental F is marked otl Patricia Alvero Clarence Wolfe ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 1/2 W.Montgomery St, Baltimore, MD, 21230 Eric Buckner/husband item 27 is 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 8/12/2008 | Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D Lohrmann P.A. 21. Signature of Funeral Service Licensee Green Pastures Dr., Towson, MD, 21286 du Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final MINNES **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner ca-die if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi and Box 68760. the attending physician The law requires that the death certificate be Physician/Medical the as IF FEMALE: asn ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Live birth 2 Fetal death 3 🗆 Ectopic pregnancy lor. Month Day Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached f P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🖼 No certificate 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day, Year) 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 0052022 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) South Hanover St Bultmore Maryland 21225

State Registrar

noble 31. Date filed (Month, Day,

300 32. Aegistrar's Signature

**ORIGINAL** 

Elliott M. Brown  4a. Facility Name (If not institution, give street and number)  Washington Adventist Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Montty Months Days Hours Min.  1. Months Days Hours Min.  August 5, 2008  2:21 AMM  4c. County of Death  Montgomery  9. Birthplace (State or Foreign Country)		1	For State Registrar					artment of I rtificate of				_	.200	8. 2	5983
## Fligiting two directions and numbers   4s. Oily, Town, or Localise of Data   ## Fligiting two direct and numbers   4s. Oily, Town, or Localise of Data   ## Fligiting two directions	sician	1	Decedent's Nam	ne (First, Middle,	Last)					2.			av Yea		me of Death
Secola Secola Personal Property National Conference   Secolar Property National Conference   Seconal Conference	edical	L									Augus	t	5, 2008	2	:21 AMM
S. Serial Security Numbers   C. See   See   T. See   See   T. See   See   T. See   See	miner	48						4b. City, Town, o	or Locatio	on of Death		40	c. County of De	ath	
The control of the		E		<u> </u>				If I Inder 1 Year				lla l		-	9-7 F
Top County   Top	eral tor	3.									(Month, Da	y, Year	) (	Country)	tate or Foreign
Montgomery   Takoma Park   188 /es 2   No   189 /es 2	.OI	Ū				70					06/23	3/19	32 N	X	
Topic carroil Ave. #1114   20912-   1	Be Completed by Funeral Director	10	Da. State	10b. County		10c. City,	Town or Lo	cation						10d. Ins	de City Limits
Topic carroil Ave. #1114   20912-   1	jo		MD	Monto	omerv	Tak	coma	Park						1 🖺	Yes 2□No
Topic carroil Ave. #1114   20912-   1	jre	10	De. Street and Nu	·				10f. Zip Code				10g. C	itizen of What C	Country?	
Comment   Comm			7051 Ca	rroll A	ve. #1114			20912	2-			U	nited S	tates	
Content   Cont	lue	1			12. Was Decedent	Ever in U.S.	13.	Was Decedent of I	Hispanic	Origin? (Specify	y Yes or No-				an,
Secondary Education   Secondary   Second	F		1 Never Mari	ried 2 Marrie	d 1						an, etc./			ite, etc.	
18. Mother's Name (Frast, Madille, Last)   19. Informative Name (Frast, Madille, Last)   19. Informative Name (Frast, Madille, Last)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Type Print)   19. Informative Name Pleistlonship (Typ			3 Widowed	4 🔀 Divorced	Year or Dates:			12100 23110	op de.	,.			Specify. E	31ack	
18. Mother's Name (First, Middle, Late)   Hazel   Phillips	ete		(Spe	15. Decedent's cify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Occu kind of work done	pation during m	ost of working	I			s/Industry	
16. Mother's Namer (Prox. Malder, Marker's Namurame)	100		Elementary/Seco	ondary (0-12)	College (1-4or	5+)			nd)			F.	inance		
Balliott Brown   Hazel Phillips   Science Care Receiver of Remains   106 Mailing Address (Sire and Alumber or Rural Reads Number, City or Town, State, Zip Code)				(F) . 1 . 1 . 1 . 1 . 1 . 1 . 1	- 0	_2	Acc	ountant	10.11		2	14 : 4	2 )		
Tight Informant's Name Pelationship (Type, Print)   Tight Mailing Address (Street and Number or Puzzi Route Number, City or Town, State, Zig Code)					151)					· ·			n Surname)		
Science Care/Receiver of Remains   2020 W. Mellinda Lane Phoenix, AZ 85027-  20a. Method of Disposition   1.0 Buris 2   Chromatics 3 & Removal from State   20b. Risco of Disposition   20b. Received Phoenix, AZ 85027-  20b. Received Phoenix   20b.	P					T			1						
20. Method of Disposition    Daniel 2   Commands   3   Removal from State		1						-				-			
Science Care   2008   Phoenix, Arizona   2008   Phoenix   Ph		-			ceiver of Re										
28. Part I. Ensire the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inApproximate shock or heart failure. List only one cause on each jine. Immediate Cause (Final disease or condition or condition resulting in death)  29. Due to (or as a consequence of):  NOS 0 Comman provided in the cause of completing in death)  29. Due to (or as a consequence of):  NOS 0 Comman provided in the cause of completing in death) Last  29. Language (Disease or injury resulting in death) Last  10. Due to (or as a consequence of):  29. Language (Disease or injury)  29. Language (Disease or inju		2		•	☑ Removal from State	20b. Plac	e of Dispo netery, crei	sition (Name of natory or other pla	ce)				•		
Rapp Funeral & Creentation Services  93 Gist Ave. silver Spring, Maryland 20910-  22. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indirect Behieved from the death of the cause (Final great of the cause).  Due to for as a consequence of):  NSO Comman product of the cause (Final great of the cause).  POSO Comman product of the cause (Final great of the cause).  POSO Comman product of the cause (Final great of the cause).  POSO Comman product of the cause (Final great of the cause).  POSO Comman product of the cause (Final great of the cause).  POSO Comman product of the cause of the		L				Sc	ience	Care				Pl	hoenix,	Arizon	ıa
28. Part I. Enset the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inApproximate shock or heart failure. List only one cause on each jine. Immediate Cause (Final disease) or confiction resulting in death)  29. Due to (or as a consequence of):  NOS 0 Comman Provincia Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or Injury resulting in death) Last  1   Very 1   Very 2   Very 3   Very 4   Very 4   Very 4   Very 4   Very 5   Very 5   Very 6   Very 6   Very 6   Very 6   Very 6   Very 6   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 7   Very 8   Very 8   Very 8   Very 9		2	Signature of Fi	uneral Service Li	censee N	100382	22	Rapp Fund	ess of Fac	cility & Cremat	ion Se	ervi	ces		
Sequentially list conditions cause consequence of):  NOSD COMMAN Productions (Cause (Final resulting in death)  Sequentially list conditions, cause Enter Underlying Cause (Disease or rillury)  Resulting in death)  Sequentially list conditions, cause Enter Underlying Cause (Disease or rillury)  Low by the accordant pregnant in the past 12 months?  1   Ves 2   No 3   Probably 4   Surface of death   1   Ves 2   No 3   Probably 4   Surface or rillury    23d. Date of delivery   Month   Day   Year    1   Ves 2   No 3   Probably 4   Surface or rillury    1   Ves 2   No 3   Probably 4   Surface or rillury    24a. Was an autopsyleron    24a. Was an autopsyleron    25c. Was case referred to medical evanual    27c. Was case referred to medica		1	State					933 Gist	Ave.	Silver	Sprin	ng,			
Due to (or as a consequence of):		2	3a. Part 1. Enter i shock, or hea	the disease, or co art failure. List or	omplications that caused by one cause on each li	d the death. ne.	Do not en	er the mode of dyi	ng, such	as cardiac or re	espiratory ar	rrest,		Interv	al Between
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FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   Month   Day   Year		1.	oguantially ti-t	andition :	NOSO	com	na	c proc	ul	nom	a			u	Us.
Due to (or as a consequence of):    FEMALE:   23d.   Mas decedent pregnant   1   1   1   1   1   1   1   1   1	ner	0 = C	equernially list co any, leading to in ause. Enter Unde	innediate erlying	Cua to (or se	a conseque	ioa ui):								
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death 4   Perpanal at time of death 5   Other (specify)   23d. Date of delivery   Month Day Year   1   Live birth 2   Fetal death 5   Other (specify)   Month Day Year   1   Live birth 2   Fetal death 4   Perpanal at time of death 5   Other (specify)   Month Day Year   1   Ves 2   No 3   Probably 4   Very Nown   1   Ves 2   No 3   Probably 4   Very Nown   1   Ves 2   No 3   Probably 4   Very Nown   1   Ves 2   No 3   Probably 4   Very Nown   1   Ves 2   No 3   Probably 4   Very Nown   1   Ves 2   No 3   Probably 4   Very Nown   1   Ves 2   No 3   Probably 4   Very Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 4   Nown   1   Ves 2   No 5   Nown   1   Ves 2   No 5   Nown   1   Ves 2   No 5   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   No 6   Nown   1   Ves 2   Nown   1	ami	C th	iai iiillialeu everili	S	C		14	2'5						cı	us.
IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   ves   v			esulting in death)	Last				1/110						1	112.
1   Yes   2   No   3   Probably   4   Definition of cause of death   1   Yes   2   No   3   Probably   4   Definition of cause of death   1   Yes   2   No   3   Probably   4   Definition of cause of death   1   Yes   2   No   2   No   2   No   2   No   2   No   2   No   No	lica	1			d. Rene	wi	, ul	jure	•					u	~3,
1   Yes   2   No   3   Probably   4   Whiknown	Med	11	FEMALE:												
1   Yes   2   No   3   Probably   4   Definition of cause of death?   1   Yes   2   No   3   Probably   4   Definition of cause of death?   1   Yes   2   No   3   Probably   4   Definition of cause of death?   1   Yes   2   No   2   No   2   No   2   No   2   No   2   No   No	an/	2	3b. Was deceden		1 Live birth	2 Fetal de	eath 3[	☐ Ectopic pregnand	су						Voor
1   Yes   2   No   3   Probably   4   Definition of cause of death   1   Yes   2   No   3   Probably   4   Definition of cause of death   1   Yes   2   No   3   Probably   4   Definition of cause of death   1   Yes   2   No   2   No   2   No   2   No   2   No   2   No   No	sici		1 ☐ Yes 2	□No	4 Pregnant a				<u> </u>				MOULU	Day	rear
1   Yes   2   No   3   Probably   4   Defining available prior to completion of cause of death?   1   Yes   2   No   3   Probably   4   Defining available prior to completion of cause of death?   1   Yes   2   No   1   Yes   2   No   25. Nanner of Death   1   Yes   2   No   26. Place of Death   1   Yes   2   No   27. Nanner of Death   1   Yes   2   No   28b. Time of Injury   28b. Time of Inj	₽	-									00. 511	- L		4- 46	
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1 Month, Day, Year)  28a. Date of Injury At home, farm, street, factory, office  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.  29b. Spracure and title of certifier  29c. License number  29d. Was an autopsy findings available prior to completion of cause of death? 1 Month of cause of death? 1 Month of cause of death? 1 Month of cause of death? 1 Month of cause of death? 1 Month of cause of death? 1 Month of cause of death? 1 Month of cause of death? 1 Month of cause of death? 1 Month of cause of death? 1 Month of cause of death? 1 Month of cause of death (Check only one)  28a. Date of Injury at Month, Day, Year) 28b. Direct of Death of Check only one)  28c. Place of Death (Check only one)  28d. Describe how injury occurred 28d. Describe how in	Þ		art II. Other signi	ficant condition	s contributing to death b	ut not resultii	ng in the u	nderlying cause giv	ven in Pai	rt I.					
25. Was case referred to medical examiner?  1		-								— Y	1 🗆 Y	res 2	2 □ No 3 □	Probably	4 Ly binknown
25. Was case referred to medical examiner?    26. Place of Death (Check only one)	ple												24b. Were	autopsy fine	lings available
26. Was case refered to medical examiner?    26. Was case refered to medical examiner?   27. Manner of Death   Mospital:   1 manufacture   28. Death of Injury   28. Death of In	Con										_ perfo	rmed?	death?	? ' _	
The continue of the continue	0			rred to medical					26. Pla	ace of Death (C					
27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury 28b. Time of Injury 3   Suicide 4   Homicide  29a. Certifier (Check only off) 29a. Certifier (Check only off) 29a. Certifier 29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)				Mo	1 Lyrinpation	ent 2 EF	R/Outpatier	nt 3 DOA Oth	ner: 4 🗆	Nursing Home	5 🗌 Resid	dence	6 ☐ Other (St	ecify)	
2   Accident 3   Suicide 4   Homicide   28e. Place of Injury At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Suprature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   A HM ED NAWAZ   Po Box 83819   Gauthers burg mo 20883   31. Date filed (Month, Day, Year)   32. Registrar's Signature		2	7. Manner of Deal		28a. Date of Init	ırv 28		28c. Inju							
29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Suprature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ALMED NAWAZ POBOX 838 19 Gawlhers burg mo 20883.  31. Date filed (Month, Day, Year)  32. Registrar's Signature	atic		2 Accident	investiga	tion	,,	juli y			□No					
29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Suprature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ALMED NAWAZ PO BOX 838 19 Gauthers burg mo 20883.  31. Date filled (Month, Day, Year)  32. Registrar's Signature	tific				t be ed 28e. Place of Inj	ury - At home	e, farm, str	eet, factory, office		28f.	Location (S	Street a	nd Number or i	Rural Route	Number,
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A NAWAZ.  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ALTMED NAWAZ POBOX 83819 Gailhers burg mo 20883.  10 31. Date filed (Month, Day, Year)  32. Registrar's Signature		2		1 Certifying	Physician: To the best	of my knowle	edge, deat	h occurred at the t	ime, date	and place, and	due to the	cause(	s) and manner	as stated.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AHMED NAWAZ POBOX 83819 Gailhers burg mo 20883.  The 31. Date filed (Month, Day, Year) 32. Registrar's Signature	edic			∠ ∟ wedical E	and manner st	ated.	n and/or in	vestigation, in my	opinion, c	eath occurred	at the time,	date ar	na place, and di	ue to the ca	use(s)
te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ž	2	96. Signature and		1-3									nth, Day, Ye	ear)
te 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature			A A	- NAU	JAZ.			05	09	87		8	3-5-	-08	
te 31. Date filed (Month, Day, Year) 32. Registrar's Signature		30	). Name and add	ress of person wi	no completed cause of c	leath (Item 2	3a) (Type.	Print)							
te 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature		1 4			0	_		19 60	win	ersb	ing	n	20 20	2880	3.
AUG 1 3 2008 March & Search &	te	-	1 1 1 1 1	- 1							0				
	ar		AHO	1 3 201	18 1000	3	hoose	1 3							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and I <i>rtificate of Death</i>	Mental Hygier Reg. ۱	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Nicholas U. Bracone	2	2. Date of Death Month  August 7	Day Year 3. Time of Death 12:00 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Anne Arunde1
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Glen Burnie If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 04/03/192	9. Birthplace (State or Foreign Country)
	yland now		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Ba-f sk	ector	Maryland Anne Arundel Glen E			1 ☐ Yes 2 📆 No
	3a or 2	io E	10e. Street and Number  100 - First Avenue West	10f. Zip Code 21061	10g. 1	Citizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it all fedical Exalt in a must be notified any once.	by Funeral Director		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	hin 72 hour e. an "natural Medical Es	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b.	Kind of Business/Industry
121	iled wit Tygien ther than	Соп	12th Sa 17. Father's Name (First, Middle, Last)	1esman	ne (First, Middle, Maid	Electronics
ylanc	2 should be fi and Mental H is marked ot raumatic ever	To Be	Nicola M. Bracone	Ma	ry Tully	
Mar	lth and 12 should 127 is m			ng Address <i>(Street and Number or Ru</i> Hollow Rock Avenu		y or Town, State, Zip Code) ster, Maryland 21157
ore,	ges 1 an nt of Hea If item 2 or other		20a. Method of Disposition  1 □ Surial 2 □ Cremation 3 □ Removal from State	osition (Name of matory or other place)	Date 20c.	Location - City or Town, State
Baltimore, Maryland	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service Accangee 2	2. Name and Address of Facility G	once Funera	altimore, Maryland al Service, P.A.
	20 E 8 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	4001 Ritchie High		more, Maryland 21225
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Journal C  Due to (or as a consequence of):	Cardions	Lo pat	Interval Between Onset and Death
68760, M	icate be executed physician and physician the burlat-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	erofic Aka	rt Dis	easp /3/earg
P.O. Box 68	eath certific attending p for use as	Physician/Medi		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	law requires that the dias been signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the Chronic Obstructive Pulmo	nderlying cause given in Part I.		co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Division of Vital Records,	The law requ ate has been page 2 should	Completed			24a. Was an autopsy performed	
Vita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Other:	ath (Check only one)	
on of	ding Physician: The In. After this certificate hit funeral director, page	ion: To	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	TIL 3 DOA 4 Nursing F	lome 5 D Residence 28d. Describe how in	6 □Other (Specify)  njury occurred
Divisio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	Hospita 24 hours Funeral stely filler	edical C	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.			
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	140.		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) /	. 1	198, 2008
	12+1 Sta	te.	Colvin Carter, W.D. 4700 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Rennington A	re, Bal	16, Md 21226
	Registr	_	AUG 1 3 2008	THE PARTY OF THE P		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician Blades 18:40 M Paul AUGUST 2006 08 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of maryland medical center Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□F Dec. 25 1947 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County JNK 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Funeral Director Preston MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a1655 24165 12. Was Decedent Ever in U.S. Armed Forces? USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Yeer or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) J 2 should be filed with....th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Devator Engineering 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should b f Health and Ment tem 27 Is marked )orothy မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston, MD 21655 Blades Mike 24165 Mallaw Dr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H.
Important: If Iter
any Injury or oth 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address Tacility Aug 17, 2008 Baltimore, MD 21. Signature of Fun Val Service Licy 1232 Midwilley Dr. Jessof, PA 18434 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Middle cerebral artery and internal carotid strike Ischemic **Physician** disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner hypo kinesis thrambus Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cause of t Due to (or es a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Lisease artery Coronary resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached for 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown probetes rellitus 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed hyperlipidences 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number

29b. Signature and title of certifier

31. Date filed (Month, Day, - Year)

Ower I. Delos

Debowy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.0.

Division

Registrar DHMH 17 Rev 1/2001

State

greene

Street

22

82. Registrar's Signature

29d. Date signed (Month, Day, Year)

Betimore MD 21201

August 10, 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25986 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 5:26 AM CHEW ANTOINE 111 08 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE HOSPITAL BALTIMORE, GOOD SAMARITAN MD 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Days Hours Min. 1 ☑ M 2 ☐ F 216-82-1582 42 Aug. 18, 1965 MD Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location **Baltimore** 1 2 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 USA 1900 Swansea Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) supervisor State Emissions Board

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Brice

BALTIMORE.

MD 21239 .

21239

20c. Location - City or Town, State

Randallstown, Maryland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

08/13/2008

22. Name and Address of Facility Wylie Funeral Home, P.A.

1900 Swansea Road; Baltimore, Maryland

**Physician** /Medical

**Physician** 

/Medical

Examiner

10a. State

MD

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print) Pearline Booker-Chew

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

Clarence J. Chew

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601,

32. Registrar's Signature

KARHADKAR

2008

ARATI

31. Date filed (Month, Day, Year)

Funeral

Director

or items 23a or 28a-f show

Director

Funeral

Be Completed by

2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event. If a Wadical Evaninar must be notified at once.

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

**Examiner** 

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

	Juneala	Jones !	638 N. Gilmor Steet;	Baltimore, Mary	land 21217
	shock, or heart failure. List only	plications that caused the death. Do not	enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	SEPSIS			Onor and Dodge
	resulting in death)	Due to (or as a consequence of):			
	0	ACUTE REN	AL FAILURE		
5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	Cause (Disease or injury that initiated events	F			
Š	resulting in death) Last	Due to (or as a consequence of):			
5		d			
;					
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
5	in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
2	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown	(-,,		
	Part II. Other significant conditions of	contributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacco u	ise contribute to the cause of death?
2	ACUTE MYE	LOID LEUKEMIA	9	1 ☐ Yes 2	No 3□ Probably 4□ Unknow
					,
-				24a. Was an autopsy	24b. Were autopsy findings availab prior to completion of cause o
5				performed? 1 □ Yes 2 🕱 No	death? 1 ☐ Yes 2 ☐ No
2	25. Was case referred to medical examiner?			eath (Check only one)	
	1 ☐ Yes 2 🔯 No	Hospital: 1 X Inpatient 2 ☐ ER/Outpa	atient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
=	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury 28b. Tim (Month, Day, Year) Injury	ne of   28c. Injury at	28d. Describe how injur	y occurred
ś	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		M 1 □Yes 2 □No		
2	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		, street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,
5	4 Difficiale	building, etc. (Opedity)		City of Town, State	/
5	29a. Certifier 1 Certifying Pt	nysician: To the best of my knowledge, d	leath occurred at the time, date and pla	ce, and due to the cause(s	) and manner as stated.
5	(Check only 2 Medical Examone)	miner: On the basis of examination and/o and manner stated.	or investigation, in my opinion, death oc	curred at the time, date and	d place, and due to the cause(s)
	29b. Signature and title of certifier	1 1	29c. License number	29d. Da	te signed (Month, Day, Year)
	29b. Signature and title of certifier  Starback	car (MD)	P20698	0	8/11/2008
		•			

20b. Place of Disposition (Name of cemetery, crematory or other place,

King Memorial Park

State

Registrar

BOULEVARD,

LOCH RAVEN

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	State Amend #30 per DV	ite of Maryland R g882 8/13	/ Depa /08	artment of H	lealth ar Death	nd Mental Hy		008	25987
*	Physici		1. Decedent's Name (First, Middle, Last)  Louise Coope:					2. Date of D Month August	eath Day	Year	3. Time of Death
7	/Medio Examir		4a. Facility Name (If not institution, give street Prince Georges' Hospital	and number)		4b. City, Town, or	-у	Death	4c. Count	y of Death	р р
-	Funeral Director		Social Security Number       6. Sex	7. Age (In yrs. lat	st birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi Min. (Month, D 09/28/	9. Birthplace (State or Foreign Country) 1928 Washington, D.C.		
	Maryland -f show fied at	tor	10a. State 10b. County PG		Town or Lo	ct Heights				10	0d. Inside City Limits 11 Yes 2 ☐ No
	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	s 23a		6412 Elmhurst Street		140.1	20747		2.0		ISA ice - America	1
920	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. ned Forces? Yes 2 No 'es, Give ar or Dates:		was Decedent of H f Yes, specify Cuba I ☐ Yes 2 X No	Specify:	n? (Specify Yes or N Puerto Rican, etc.)		ack, White,	etc.
21215-0036	within 72 hc iene. than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade complete (0-12)  Elementary/Secondary (0-12)	llege (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired <b>tra Nurse</b>	durina most c	of working	16b. Kind of E		·
	filed v Hygie other i		17. Father's Name (First, Middle, Last)	5	Negris	ua Nuise	18. Mother's	s Name (First, Middle	D.C. Go , Maiden Surna		10
/lan	should be fand Mental B s marked of umatic eve	To Be	Douglas Walker				Marie	• Valentine		, 	
Maryland			19a. Informant's Name/Relationship (Type. Pr Linch Dupree - Daughter	int)				or Rural Route Numi e Hills, Mar	-		Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 i any Injury or other tra once.	- 2	20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Remove	of from State	ce of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location	- City or To	
Itim	permit. Pag Department Important: I any Injury o		4 □ Do ation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Harm		norial Park	i	8/09/2008 Freeman Fune	Landover		land
Ba	permit. Departr Importa any Inji		Yundanut	Ulmar	71			emple Hills,			3
8760,	Physician whysician and physician and physician and the printertransit the buriar-transit the printer and the	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underwijing Cause (Disease or injury that initiated events	oue to for as a conseque	ence of):	Ene.	e pl	le gr	The state of the s	)	Approximate Interval Between Onset and Death
O. Box 68	ath certific attending p for use as	Physician/Medi	in the past 12 months?	es, outcome pf pregnand ]Live birth 2	leath 3	Ectopic pregnancy	'			ate of delive	ry Day Year
Δ.	uires that the de signed by the Id be detached i	þ	Part II. Other significant conditions contribution	death but not result	ing in the ur	nderlying cause give	en in Part I.		tobacco use cor		e cause of death? ably 4 □Unknown
al Records,	The law ate has b page 2 sl	Completed	Demen	lia				24a. Was auto perl 1 Yes	s an 24b opsy ormed? 2 No	prior to cor death?	osy findings available npletion of cause of
Vital		o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospita	l: 1 Dinpatient 2 ☐ El	R/Outpatien	t 3 DOA Otho	er.	if Death (Check only ing Home 5 ☐ Res		thes (Casaife	Α
n or	ng Phys fter this neral di	H- 1			28b. Time of Injury				how injury occu		7
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	Accident investigation	. Place of injury - At hom building, etc. (Specify)	ne, farm, stre	M 1 🗆	Yes 2⊡No	28f. Location	(Street and Num wn, State)	aber or Rura	l Route Number,
	ne Hospital n 24 hours a ne Funeral oletely filled	Medical C	(Check only 2 Medical Examiner: O	To the best of my knowl n the basis of examination d manner stated.	ledge, death on and/or inv	occurred at the tirvestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	e cause(s) and n	nanner as st	ated. the cause(s)
	To the vithing to the complete complete the	Ĭ	29b. Signature and title of certifier			29c. Licenso	e number		29d. Date sign	ed (Month, I	Day, Year)
	1		1/ Fort			6	50 8	3/8	8/4	1/05	-
	7		30. Name and address of person who complete	· ·					00707	, ,	
No.	Sta	te.	Demetrios James Cater 31. Date filed (Month, Day, Year).				r. Che	verly, MD	20/85		
	Registr		AUG 1 3 2008	32. Rigistrar's Signatu	to fig	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of M	aryland	l / Depa Cer	rtment of F tificate of	lealth and I Death	Mental Hy	giene	2008	25988
			1. Decedent's Name (First, Middle, Last)		061	incate or		2. Date of De	ath		3. Time of Death
	Physici /Medic		John W. Chap	man				Month August	Day <b>7</b>		5:35 A <sup>M</sup>
- 100	Examir		4a. Facility Name (If not institution, give street and number)	)		4b. City, Town, o	r Location of Deatl	1	4c.	County of Death	
e a sta			Brighton Gardens  5. Social Security Number 6. Sex 7. Ac	na (la ima lai	n & brimble alone (		ville I If Under 24 Hrs.	8. Date of Bir		lontgomer	
	Funeral Director		207-16-0451 1⊠ M 2□ F	ge (In yrs. las 85	Yrs.	Months Days	Hours Min.	January	ay, Year)	23 Rhode	place (State or Foreign ntry) e Island
	pu ^		Usual Residence of Decedent		T			Journal	.,		
	Aaryla f shov	ō	10a. State		Town or Loc					1	1 ☐ Yes 2 X No
	the A	Director	Maryland Montgomery  10e. Street and Number	NO	orth b	ethesda 10f. Zip Code			10g, Cit	zen of What Cour	
	th with 23a o		5550 Tuckerman Lane, Apt	342		208	52		Uni	ted Stat	es
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a "Folical Examinar must be notified at once.	Funeral	11. Marital Status  12. Was Decedent Armed Forces?  1 □ Never Married 2 ☒ Married  1 ☒ Yes 2 □	>	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	)-	14. Race - Americ Black, White,	
036	urs af al", or Exem	Þ	3 ☐ Widowed 4 ☐ Divorced	WO MMIT	1	□Yes 2No	Specify:			Specify: Wh	nite
5-0	72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	Ţ	(Give I	ent's Usual Occup	during most of wor	king	16b. Ki	nd of Business/Inc	dustry
121	within ene. <b>than</b>	dmc	Elementary/Secondary (0-12) College (1-4or 5 5+	5+)		OONOT use retired essor	d)		11.	iversity	7
1d 2	il Hygi other rent, I	Be C	17. Father's Name (First, Middle, Last)			<u> </u>	18. Mother's Nan	ne (First, Middle			
ylar	uld be Menta arked atic ev	10 E	John W. Chapman, II				Hazel Y	oung			
Mar	2 sho n and risma rauma		19a. Informant's Name/Relationship (Type. Print)				and Number or Ru				*
e, N	1 and Health em 27 ther t		Janet G. Chapman / Wife  20a. Method of Disposition					pt. 342		th Betheso	da, MD 20852
Baltimore, Maryland 21215-0036	ages ent of nt: If its y or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of eatory or other place rematorium	: A	ugust , 2008		•	•
altii	rmit. F spartm portar y injur		21. Signature of Funeral Service Licensee	TROTTEG	22	Name and Addres	ss of Facility			nesda, M	
<u> </u>	9 9 E E 8		11 - 1-00-1	M01305	/5	o/ Wisconsi	in Avenue,	Bethesda,	Mary	esda-Unevy 1and 20814	Chase, Inc.
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	d the death. ne.	Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
· was	Physician /Medical		resulting in death)	ate Ca							Onset and Death
	Examiner		Due to (or as			Heart Dis	2020				
	P #	ner	Sequentially list conditions, if any loading to immediate cause. Enter Underlying		-						
	ecuter and -transi	Examiner		ation		onia					
68760,	tificate be executed g physician and as the burial-transit		2 40 10 (01 40		,	Accident					
		ledical	0.			- 10			1	10/25	
Box	eath certific attending p for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome			Ectopic pregnance	v		1	23d. Date of delive	
o.	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown	ıt time of dea	ath 5□	Other (specify)				Month	Day Year
ď.	ires that i signed by I be deta	by Ph	Part II. Other significant conditions contributing to death b	ut not resulti	ing in the un	derlying cause give	en in Part I.	23e. Did t	obacco u	se contribute to th	he cause of death?
Records,	w require been sig should b	ted b						1 🗆 '	Yes 2	∑ No 3 ☐ Prob	oably 4 🗌 Unknown
ဒ္ဓင္	law r has be e 2 sh	Completed						24a. Was autop	osy	24b. Were auto	psy findings available mpletion of cause of
								1 □Yes	rmed? 2 No	death? 1 □ Yes	2 🗆 No
Vital	rsician: s certific lirector,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🕅 No Hospital: 1 ☐ Inpatic	ent 2 EF	7/Outmotion	Othe	26. Place of Dea				
סָ	Attending Physician: ir death. ector: After this certific by the funeral director, I	n: To	27. Manner of Death 28a. Date of Inju	urv 28	8b. Time of	28c. Injury	4 KM Nursing H	ome 5 Resi		Other (Specify occurred	у)
Sior	endin sath. or: Af the fur	atio	2 Accident investigation	y, rear)	Injury		Yes 2 □No				
Division of	e Hospital or Attendi 24 hours after death. e Funeral Director: A letely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injustion 4 ☐ Homicide determined 28e. Place of Injustion 1997.	ury - At home c. (Specify)	e, farm, stre	et, factory, office		28f. Location (3 City or Tox		d Number or Rura )	d Route Number,
	spital		29a. Certifier 1 Certifying Physician: To the best	of my knowle	edge, death	occurred at the tir	ne, date and place	, and due to the	cause(s)	and manner as s	stated.
	the Hos in 24 hd the Fun ipletely	edical	(Check only one)    Medical Examiner: On the basis of and manner sta	of examination	n and/or inv	estigation, in my o	pinion, death occu	rred at the time,	date and	place, and due to	the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	1 -		29c. License			29d. Dat	e signed (Month,	Day, Year)
	~		30 Norman State of the State of	20	0-1/2		53691		Aug	ust 7, 2	2008
12	++1		30. Name and address of person who completed cause of d Ajay Reddy, M.D. 6320 Dem		, , , , ,		esda, Mar	vland 2	0817		
İ	Sta		21 Data filed (Month Do.) Voca	hala Cianatur			Jan, Hal	Janua 2	5511		
	Registr	ar	AUG 1 3 2008	Red Sal	J. J.	GD34W					

WilliAM CONCO, SS # 166185215
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For				artment of F			giene	С.	
	•	For State Registrar		•	•	rtificate of l			leg. No. 20 (	18 259	89
Physicia	ın	1. Decedent's Name (First, Middle, Las						2. Date of Dea Month	Day Ye	3. Time of Dea	
/Medic	al	4a. Facility Name (If not institution, give		NC	0	4h City Tourn or	- Location of Dooth	Month 8	12 200 4c. County of		4м
Examine	er		ITAN HO.	ri 92	AL		r Location of Death	ı	N/A	Jeam	
Funeral		Social Security Number 6. S		e (In yrs.	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	(Year) 9.	Birthplace (State or For	reign
Director		Usual Residence of Decedent	WI ZLI F	84	Yrs.			12/30	/1923 Pe	ennsýlvania	
yland how		10a. State 10b. County		10c. City	, Town or Lo	ocation				10d. Inside City Lin	mits
e Mar 8a-f sl	cto	MD N/A		Bal <sup>-</sup>	timore					1 X Yes 2 □	]No
be filed within 72 hours after death with the Marylan Hygiene Hygiene Hygiene Hygiene Hours of the Warylan and other than "natural", or items 23a or 28a-f show event, the Medical Examination at	Funeral Director	10e. Street and Number 1601 East Belvede	re Avenue			10f. Zip Code 21239			I0g. Citizen of Wha	it Country?	
death ms 23	nera	11. Marital Status	12. Was Decedent 8	Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S		14. Race -	American Indian,	
or ite		1 Never Married 2 Married	Armed Forces? 1 XYes 2 ☐ N If Yes, Give Year or Dates:	WW T T		1 ∐Yes 2 ⊠No	Specify:	o Hican, etc.)		White, etc. White	
hours tural"	Completed by	3 X Widowed 4 ☐ Divorced  15. Decedent's Edi				dent's Usual Occup			16b. Kind of Busin		_
hin 72 e. an "na Medic	plet	(Specify only highest grad	de completed)  College (1-4or 5	+)	(Give life.	kind of work done of DO NOT use retired	during most of wor d)	king		,	
ed wit lygien her tha	So	Elementary/Secondary (0-12)		.,	Self	Employed				le Produce	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. The managed of the than "natural", or items 23a or 28a-f show umatic event, the Medical Examinations to a continuation of the managed	Be	17. Father's Name (First, Middle, Last)  Gregory Conco						ne <i>(First, Middle, i</i> ne Miris:	Maiden Surname)		
should and Me mark umatic	ဍ	19a. Informant's Name/Relationship (7	ype. Print)		19b. Maili	ng Address (Street				ate, Zip Code)	
1 and 2 Health a lem 27 is		Katherine Conco,	Daughter		4154	Double T	ree Lane	, Hampst	ead, MD 2	21074	
Profits of the second of the s		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State			osition (Name of matory or other place			20c. Location - Cit		
nit. Paç artmen ortant: injury E.		4 ☐ Donation 5 ☐ Other (Specify  21. Signatere of Funeral Service License	)	St.		ew Cemete  2. Name and Addres				, Maryland	
permi Depar Impor any ir		21. Signatore of Puneral Service Licens	Blair		I	305 Harfo	<u>-</u> -	eonardaj Baltimo	. Ruck, 1 re. MD 21	nc. 1214	
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death	1					Approximate Interval Between	n
Physician		Immediate Cause (Final disease or condition	seps							Onset and Death	.h
/Medical Examiner		resulting in death)	Due to (or as								
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ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underning Cause (Disease or injury that initiated events	с								
ate be executed hysician and he burial-transit	cal Ex	resulting in death) Last	Due to (or as	a consequ	ience of):						
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	•-		d								
eath certifical attending phy for use as th	Physician/Med	Zob. Was decedent program	23c. If yes, outcome		ncy doath 3	☐ Ectopic pregnanc			23d. Date o	of delivery	
e deal	sicis	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at			Other (specify)	у		Month	Day Year	
that the de ned by the		Part II. Other significant conditions co	ntributing to death bu	ıt not resu	ilting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	ite to the cause of death	1?
w requires to be signed should be consigned.	d by					, , ,		1 □ Y	es 2⊡No 3[	Probably 4 Onkn	nown
e law rec has bee e 2 shou	Completed							24a. Was a		re autopsy findings avail	lable
The sate has page	E C							autops perfori	med?// dea	r to completion of cause ith? ÌYes 2 ☐No	) OI
yslcian: Thinis certificate	Be	25. Was case referred to medical examiner?	Hospital:			Othe	0.81	th (Check only on			
ding Phys	٤	1 Yes 2 1 1 1 1 1 2 2 1 1 1 1 1 2 1 1 1 1 1	28a. Date of Injur	ry T	28b. Time o	f 28c. Injur	y at		ence 6 Other owninjury occurred	(Specify)	
ath. rr: Afte	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	ı, Year)	Injury	M 1 🗆	k? Yes 2 □No		,,		
or Atter frer de pirecto in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ry - At ho . (Specif)	me, farm, str	eet, factory, office		28f. Location (S: City or Town	treet and Number on, State)	or Rural Route Number,	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, page 200.	ချ	29a. Certifier 1 Certifying Phy	sician: To the best of	of my know	Wiedne deat	h occurred at the tir	me date and place	and due to the	sauco(c) and mann	or an atatad	
n 24 h	edical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examina	tion and/or ir	ivestigation, in my o	ppinion, death occu	rred at the time, o	late and place, and	I due to the cause(s)	
To the complete compl	ž	29b. Signature and title of certifier	1 -	0.0	۸	29c. License		2	29d. Date signed (A	4	
1		Tamis Bu	· · ·				5000		08/12	2/2008	
2		30. Name and address of person who can also and address of person who can also a supplied to the supplied to t		eath (Item	23a) (Type,	Print) NBUVd	Balt	more	MA 2	1239	
Stat	е	31. Date filed (Month, Day, Year)	22. Registra	ır's Signat	ure		,	,	, , , ,		
Registra	ır	AUG 1 3 2008	Marias.	H.	Sman	Cari					

## **VOID**

# CERTIFICATE #

2008-25990

# SEE

# **CERTIFICATE** #

2008-26167

Deciased Dinise D. Luepepper Danis

D.O.H- 8/7/2008

amenifere Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edward A Crooke 2008 10 6:35 P M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11813 Farside Road Ellicott City Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 **M**M 2 □ F Director 219 36 9950 70 July 6, 1938 Washington DC Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Howard Ellicott City 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? "natural", or items 23a odical Examiner must b 11813 Farside Road 21042 United States Pages 1 and 2 should be filed within 72 hours after death in the filth and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No if Yes, Give Year or Dates: 1956-64 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: 3 Widowed 4 Divorced White or than "natura the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) i and Mental Hygiene. Is marked other than Vice Chairman Constellation Energy 17. Father's Name (First, Middle Crooke 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Davis Cooke, Sr. Anne Patricia Austin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Lois Ann Crooke/Wife 11813 Farside Road Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Cemetery 8-16-2008 | Glenwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitHarry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Telanomo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□ Yes 1 ☐ Yes 2 🖼 No 2 **X**No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 038400 11/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) [27 [2] Comerille Sharton Palls Rd HYIT Minn 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DI MAIO Katherine 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Place 15 Esther Assisted Liv. BALL 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🗙 F Months Days 220-14-465 Director -6613. 1915 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I ferm 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must han action of the contract of the medical Examinar must han action of the contract of the medical Examinar must han action of the contract of the medical Examinar must han action of the contract of the medical Examinar must han action of the contract of the medical Examinar must han action of the contract 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2831 W.S.A 21214 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ 3. Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) OSE SHANIS Elementary/Secondary (0-12) College (1-4or 5+) CLERK -TELLER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) Gluseppe ELLEGRINE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Weido 6674 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AKLAWN CEMETERY Aug 15,2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Joseph N. ZANNINO

2635. CONKLING ST FUNCAR CONKling St. Brito 21224 mplications that caused the death. Do not enter the mode of dying, such as cards c or respiratory arrest y one cause on each line. Approximate Interval Between Onset and Death 23a. Part Filer the lise shock, or heart File Immediate Cause (final disease or condition resulting in death) eimers disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant-3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8/11/08

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Hopkins Bayview Circle

21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL C. Durso, MD 5505 Hope

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink Freure All Copies Are Legible

			1 - For State Registrar	State of Maryland		artment of Health a	_	giene Reg. No 2008	25993
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Las Syln 4a. Facility Name (If not institution, give 215, CARVER	EDAY J	DAUI	4b. City, Town, or Location of	2. Date of D. Month August		3. Time of Death
	Funeral Director	1	5. Social Security Number 6. Sr 219-74-7034 1		a <i>st birthd</i> ay) Yrs.	If Under 1 Year If Under 2. Months Days Hours		rth 9. Bir	thplace (State or Foreign ountry) NARY/AND
	with the Maryland a or 28a-f show be notified at	Director	Usual Residence of Decedent  10a, State  10b, County  HARY And  10e, Street and Number	1 0	Town or Lo	l Of. Zip Code		10g. Citizen of What Co	10d. Inside City Limits 1 ★Yes 2 No
9600	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Examiner must be notifled at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	1	Nas Decedent of Hispanic Origi f Yes, specify Cuban, Mexican, □ Yes 2 No Specify:	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ame Black, Whi	American
121215-0036	ed within 72 /giene. er than "na" t, the Medic	Completed	15. Decedent's Ed (Specify only highest gra. Elementary/Secondary (0-12)	ucation de completed)  College (1-4or 5+)	18a. Deced (Give life. L		ministrate		Industry Soverment
Maryland	2 should be file and Mental Hy is marked oth is marked oth	To Be	17. Father's Name (First, Middle, Last)  RA4Field Fal Son  19a Info mant's Name/Relationship (7	ýpe. Print)	19b. Mailin	Red Address (Street and Number	or Bural Boute Numb	mpson mer City or Town State	Zip Codę)
Baltimore, M.	ges 1 and 2 t of Health If item 27 I		Kamiesha (Jal)  20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donayion 5 Other (Specify	Removal from State	ace of Dispos	old FREDERI sition (Name of natory or other place)	Date  Date  Date  Date	20c. Location - City or	41229
Balti	permit. Pa Departmen Important: any Injury once.		21. Signature of Funeral Service Licen	Lillar	22 N 34	Name and Address of Facility  Ancy m William  Column Familia	street By	TIMOLE, TIME	YMIN DIGGI
	Physician /Medical Examiner		23a. Part. Enter ye disease, or comp shock, or hely failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence)	. (	- Ly Chro	ardiac or respiratory a	irrest,	Approximate Interval Between Onset and Death
0,	3	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b					
ox 68760,		/Medical	IF FEMALE:	d	CV				
P.O. Box	The law requires that the death certifica te has been signed by the attending phage 2 should be detached for use as the	Physician/Med	in the past 12 months?  1 Yes Too	1□Live birth 2□Fetal of 4□Pregnant at time of dea	death 3 ath 5	Ectopic pregnancy Other (specify)		23d. Date of de Month	Day Year
Records,	w requires the been signed should be do	ò	Part II. Other significant conditions co	intributing to death but not resul	ting in the un	derlying cause given in Part I.	\		robably 4 □Unknown
		Be Completed	25. Was case referred to medical examiner?			26. Place o	auto	psy prior to death? No 1 □ Yes	utopsy findings available completion of cause of
ision or	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director,	Certification: To I	27. Manner of Deal  1 Natural 2 Naccident 3 Suicide 4 Homicide	1	R/Outpatient 28b. Time of Injury ne, farm, stre	28c. Injury at Work? M 1 Yes 2 No	28d. Describe	dence 6 Other (Spe how injury occurred Street and Number or Re wn, State)	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	one) 2   Medical Exam	sician: To the best of my know iner: On the basis of examination and manner stated.	ledge, death on and/or inv	estigation, in my opinion, death	place, and due to the occurred at the time,	date and place, and due	e to the cause(s)
	¥ × × 8		29b. Signature and title of certification.  30. Name and address of person who comes are addressed to the company of the compa	ompleted cause of death (Item 2	23a) (Type. P	29c. License number	y F	29d. Date signed (Mont	ROUS

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. perMD, 8882 8/22/08 TT State of Maryland 7 Department of Health and Mental Hygiene Amend #1, perMD, 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Susie Clara Day 2. Date of Death **Physician** Month Year 5:00 PM August 08 2008 Day /Medical Clare 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore
1 Year | If Under 24 Hrs Union Memorial Hospital
5. Social Security Number 6. Sex 7. Age If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Fune III Months Days Hours 1 □ M 2√□ F Yrs 78 Director 215-46-6047 15 MD Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits show 10a. State 10b. County 1 ▼ Yes 2 No other traumatic event, the Medical Examiner must be notified Be Completed by Funeral Director Baltimore NA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21218 permit. Pages 1 and 2 should be filed within 72 hours after death volument of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or Items 23s any injury or other traumatic event, the "Modical Examiner must 2707 The Alameda 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√ No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12th grade College (1-4or 5+) 2yrs Home Care Provider State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Bertha Yorkshire James Henry Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2713 Beckon Drive, Edgewood, Md 21040 Risa Day-Jackson-Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 8/14/08 Baltimore, Md 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Smala March F/H East 1101 East North Ave, Baltimore, Md21202 23a. Pg/ 1. Enter the disease, or complications that on used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Implediate Cause (Final difference or condition resulting in death) **Physician** ANDRIC ence phalo path. /Medical Due to (or as a consequence of): Examiner activity heart electrical Sequentially list conditions, if any leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or as a nonsequence of) or Attending Physician: The law requires that the death certificate be executed Hyper ten sion Due to (or as a consequence of) Box 68760 physician IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown ly per tension, Dinbetes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury s after dea.. •ai Director: Aftr 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 THomicide within 24 hours a
To the Funeral C 29a. Certifier 1 \*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Angust/08/2008 2438946 Alcheil h Elic 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alcheich Elie Union Memorial 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1 2008

**ORIGINAL** 

To the Hospital or Attending Physicians Certification: n 24 hours after death.

e Funeral Director: A letely filled in by the fu 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E August 11, 2008 ted cause of death (Item 23a Theodore M. King, Jr., MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 0937 AM Darago Jonathan Anthony 2008 /Medical 05 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death MedicalCer If Under 24 Hrs. o Maryland timere N/A If Under 1 Year Social Security Number Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Days 1 X M 2 □ F Min. Country Director 08/05/2008 8 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shamy injury or other traumatic event, Ital Madical Evant and the molified once. Director 1 Yes 2 No Rosedale MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21237 USA Funeral 5105 Castlestone Dr. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No δ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dependent N/A 0 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Moore Rachel ပ္ Albert Anthony Darago III 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Darago (grandmother) Gainesville, GA. 30506 9035 Farm Shaw Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 08/11/2008 Towson, MD. signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, MD. 21222 Dundalk, Inc. 7922 Wise Ave. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to ur as a consequence of): /Medical Examiner AGENESI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Segu Exami acter burial-trar and Due to (or as a consequence b) attending physician for use as the buria certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the detached 9 I Unknown 9 Unknown signed by the detact The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ No 3 Probably 4 Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate perform 1 ☐ Yes 2 No 1 Yes 2 No Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No မ 2 ER/Outpatient 3 DOA this After this funeral c 27. Manner of Death Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760. P.O. Records, of Vital Division

Hospital or Attending To the Hospitan C. within 24 hours after death.

To the Funeral Director: A'

> State Registrar

Fernando 31. Date filed (Month, Day, Year) AUG 13 2008

29b. Signature and title of certifier

mandi

29a, Certifier

(Check only one)

Medical

29c. License number

DOOL 2150

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22

South Greene Street

Balto,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25997 State of Maryland / Department of Health and Mental Hygiene 2 U U 8 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month -oster 0555 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Medical Centu Maniand lhmore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 1 → M 2 □ F Days Hours 230-64-8558 58 Director 0-14-1949 VΑ Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the modical Evantines must be notified at 10c. City, Town or Location 10d. Inside City Limits XX<sup>Yes</sup> 2□No Director Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 606 W. Franklin Street 21201 Funeral apt USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes ZYNO If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 à 1 ☐Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4th grade Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Willis Foster ပ္ Lenora Woodson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 Valeria Foster-Wife 606 W. Franklin Street Apt 2 Balto, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Carmel Cem 8-13-2008 Balto,  $_{\rm MD}$ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue 0 Balto, u MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oronary resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi physician and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as 1 attending p IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Month Day Year the ☐Yes 2☐No 5 Other (specify) g | Unknown 9 Unknown þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page autopsy perform certificate 1 □ Yes 2 NO 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**V** No 1 Tes this Medical Certification: To 1 Ninpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5 Name and address of person who completed cause of death (Item 23a) (Type, Print) Kuppusami 3 2008 32. Registrar's Signature 31. Date filed (Month, State Registrar

08-05999 UNK UNK

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 25998

INIX OINIX		Certificate of Death
Physiciar	1/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year
7 al Examin		ARIEL FERNADEZ  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
		3320 Abingdon Road Abingdon Harford
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min.
Director	9	059-76-7860 1 M 2 F 20 Yrs. Months Days Hours Mill. 06-13-1988 Country) NY Usual Residence of Decedent
any	ŀ	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryland 28a-f show d at once	ę.	ND $NB$ $SelcamD$ $1X Yes 2 No$
the a stiffied a		10e. Street and Number  4300 Winners Circle  10f. Zip Code  21017  10g. Citizen of What Country? USA
death with r items 2:	Funeral	11. Marital Status 1 Never Married 2 Married 2 No Married
s after or ral", o	by F	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: Specify:
5-0036 led within 72 hours after Hygiene, other than "natural", the Medical Examiner.	ge	Elementary/Secondary (0-12) College (1-4 or 5+)
1036 Aithin 72 ene. er than	ompleted	12 auto Mechanic Mechanical
21215-0036 Sold be filed within 7 Mental Hygiene marked other than to event, the Medica	ပ္စု	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  18. Mother's Name (First, Middle, Maiden Surname)  18. Mother's Name (First, Middle, Maiden Surname)
ore, MD 21215-00; es 1 and 2 should be filed with of Health and Mental Hygiene If item 27 is marked other 1 ther traumatic event, the Me	P P	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rucal Route Number, City or Town, State, Zip Code)
Md 2 alth alth aura		Towas Ternsder Farther 4609 4th Ave 1500 Hyn NY 11220  20a Method of Disposition   20b. Place of Disposition (Name of cemetery,   10ate / 20c. Location - City or Town, State
Baltimore, permit Pages I a Department of He Important: If ite		1 Deurial 2 Cremation 3 Removal from State Commenter or or other place)  Commenter or or other place)  Commenter or or other place)  Commenter or or other place)  Commenter or or other place)
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Balti permit Departr Import injury		Torum & Howell SV 4600 UBERTY Hitt. Be 175, mp 2:207
hysician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Authorized the death in the desiration of the death in the desiration of the death in the desiration of the death in the desiration of the death in the desiration of the death in
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	إ	Sequentially list conditions,  b
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated
ted 1 ansit	Exa	events resulting in death) Last Due to (or as a consequence of):
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760, Teate b		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 25c. If yes, outcome of pregnancy 23d. Date of delivery 25d. Was decedent pregnant in the 25c. If yes, outcome of pregnancy 25d. Date of delivery
Box 687 e death certific the attending p	iciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
	Physician/	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
, P.O. ires that the signed by		1 Yes 2 No 3 Probably 4 Unknown
cords, law requin	Completed by	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Reco The law cate has	omo	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
of Vital Records, ig Physician: The law requirement. The the requirement that the this certificate has been some a director, page 2 should be	Bec	25. Was case referred to medical examiner?
1 of VI ding Physic After this funeral dir	욘	1 ✓ Yes 2 No Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion ( fending eath. or: Al	Certification:	1 Natural 5 Pending Aug 5, 2008 2254 hrs 1 Yes 2 ✓ No Driver of vehicle involved in collision
Division spital or Attendii hours after death. meral Director:	tiţic	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospita 24 hours Funeral		4 Homicide determined (Specify) Street 3320 Abingdon Road, Abingdon, MD  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To With	ğ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
4		Tatricia (Menica-Pollohis O.C.M.E. August 6, 2008
2'		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature
Regist		AUG 1 3 2008 103 049 15 100 100 100 100 100 100 100 100 100
DHMH 17 Rev 1/20 OCME 2006	101	ORIGINAL

			For State Registrar	State of Maryla		artment of F <i>rtificate of</i>		d Mental Hy	giene Reg. No. 2 (	800	25999
0	Physici /Medic		1. Decedent's Name (First, Middle, Las		RIAS		-	2. Date of De		Year	3. Time of Death A
7	Examin	ier	4a. Facility Name (If not institution, give Mandrin Hospice H			4b. City, Town, o Harwood	r Location of De	eath	Anne A		el
2171.31	Funeral Director		400-34-3427	ex 7. Age (In yi	rs. last birthday) 95 Yrs.	Months Days	If Under 24 H Hours M		1th Year) 1912	. Coun	lace (State or Foreign stry) ntina
YIATIG Z IZIO-0030  ould be filed within 72 hours after death with the Maryland	permit. Pages 1 and 2 should be jiled within 72 hours after death with the Maryland Department of Health and Mental Heart between the Department of Health and Mental Heart between 17 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County MD Prince G  10e. Street and Number 2607 Enterprise R  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  (Specify only highest grant Elementary/Secondary (0-12)	eorge's Mi  oad  12. Was Decedent Ever in Armed Forces? 1	16a. Dece	7111e  10f. Zip Code 20721  Was Decedent of I- If Yes, specify Cub  1 □ Xyes 2□ No  dent's Usual Occup, kind of work done DO NOT use retired	Specify: A	(Specify Yes or No lerto Rican, etc.)		What Counce - Americ ck, White, fy: Whi	an Indian, etc. †e
	buld be filed Mental Hyg arked othe atic event,			car Alberto Farias Julia Maria Mazetti					,		
, Mar.	and 2 sho ealth and n 27 is ma ner trauma		19a. Informant's Name/Relationship (Susan B. Posko/da	ughter	1508	ng Address (Street Circle D	rive Anı	napolis,	per, City or Town MD 2140	, State, Zip 9	Code)
baltimore,	rages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Themoval from State		osition (Name of matory or other place Ke Cremate		Date 8/12/08	20c. Location Beltsvi	•	
VILai necolus, P.O. BOX 00/00, C.	hysician /Medical Examiner	Physician/Medical Examiner	23a. Part1. Enter the Jesease, or comshock, or heart allure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the de	101251Be eath. Do not en		Heckro	tte. P.A.	Clarks		, MD 21029 Approximate Interval Between Onset and Death
	cate ohys the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf prec 1 □ Live birth 2 □ Fr 4 □ Pregnant at time o	gnancy etal death 3[	□Ectopic pregnanc: □ Other (specify)	у			ate of delive	ery Day Year
	v requires mai been signed k should be deta	by	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	inderlying cause giv	ren in Part I.	_ 1□	Yes 2 No	3 ☐ Prob	
		Be Completed	25. Was case referred to medical examiner?				26. Place of D	24a. Was auto perfo	psy ormed? 2 No	were auto prior to cor death? 1 Yes	psy findings available inpletion of cause of
	I on the ropering of Amending Frigst within 24 hours after death.  To the Funeral Director, After this of completely filled in by the funeral dire	Certification: To	1   Yes   2   No						rred	7,0	
Laenit	ne nospire n 24 hours he Funera pletely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deat ination and/or ir	th occurred at the time	me, date and pla opinion, death o	ace, and due to the ccurred at the time,	cause(s) and m , date and place,	anner as st	tated. the cause(s)
) 1	vith To t	M	29b. Signature and title of certifier	Henta	M	29c. Licens	e number	38	29d. Date signe	ed (Month,	Day, Year) 11, 2,008
	24		30. Name and address of person who all the state of person who are stated and address of person who are stated as a state of person who are stated as a state of person who are stated as a state of person who are stated as a stated as	completed cause of death (It	ru( )	EFENSE	Hotel	NAY AN	NAPOUS	, mo	V140)

DHMH 17 Rev 1/2001

Registrar

AUG 1 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Evanstive OB /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Baltimore
If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) 5-20-191 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M **%** □ F Director 219-12-5178 -20-1919 89 S.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1∏Yes 2∏No Director N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2009 Boone Street 21218 U S by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautican Self Employed 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver Wilson <u>Nancy Davis</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera Wilson-Daughter 2009 Boone Street Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cem 8-19-2008 Anne Arundel Co, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H lady 1101 E. North Avenue Balto, MD 21202 wans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 Z No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE 28b. Time of Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? To the Hospiter ... within 24 hours after death.
To the Funeral Director: After ... manletely filled in by the fur 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H006 426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) inder Av. Baltimore, Mb. 2001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar